PS COMMITTEE #1
September 25, 2008
Worksession

MEMORANDUM

TO: Public Safety Committee

FROM: Michael Faden, Senior Legislative Attorney
Minna K. Davidson, Legislative Analyst

SUBJECT: **Worksession:** Bill 25-08, *Emergency Medical Service Transport Fee - Imposition*

The following are expected to attend this worksession:
Kathleen Boucher, Assistant Chief Administrative Officer
Tom Carr, Fire Chief, Montgomery County Fire and Rescue Service (MCFRS)
Scott Graham, Assistant Chief, MCFRS
Joe Beach, Director, Office of Management and Budget (OMB)
Marc Hansen, Deputy County Attorney

Bill 5-08, *Emergency Medical Services Transport Fee – Imposition*, as originally proposed, would authorize the Fire and Rescue Service to impose and collect a fee to recover costs generated by providing emergency medical service transports. This bill would also provide for a schedule of emergency medical services, transport fees, fee waiver criteria, permitted uses of fee revenues and other procedures to operate the emergency medical services fee program. Bill 25-08 would prohibit a local fire and rescue department from imposing a separate emergency medical services transport fee. The Executive would be required to issue regulations to implement the fee. A proposed regulation was advertised in the June County Register.

Bill 25-08 was introduced on June 10 by the Council President at the request of the County Executive; the Public Safety Committee received an overview of the Emergency Medical Services Transport (EMST) fee on June 26; the Council held a public hearing on July 8; and the Public Safety Committee held a worksession on July 24.

The July 24 Public Safety Committee packet contained many documents related to Bill 25-08, including the proposed bill and regulation, Legislative Request Report, Executive Implementation Plan, Fiscal Impact Statement, selected public hearing testimony, and other relevant information. To review these materials, refer to the July 24 packet, available online at: http://www.montgomerycountymd.gov/content/council/pdf/agenda/cm/2008/080724/20080724_ps04.pdf.

Executive Amendments

During the public hearing, William Sullivan provided a letter (see © 74) from the Government Employees Health Associate (GEHA) stating that GEHA would deny a claim for a Montgomery County EMST fee because GEHA will not cover services or supplies for which no charge would be made if the covered individual had no health insurance. Other insurance programs contain similar exclusions.

After the public hearing, Council staff asked the County Attorney to provide opinions on two questions regarding the EMST fee. The questions and the County Attorney's responses are summarized below. The County Attorney's opinion is attached on © 5-26.

- Does the provision of Bill 25-08 which says that a County resident is responsible for payment of the EMST fee only to the extent of the resident's insurance coverage (the "insurance only provision") provide a legal basis for health insurance carriers to deny payment of the County's proposed ambulance fee?

In short, the Deputy County Attorney found that under the "insurance only provision", most private health insurance carriers would have a legal basis for refusing to pay a claim for a County EMST fee. However, Bill 25-08 could be amended to impose a fee on all ambulance users but provide that taxes collected by the County would be deemed as payment on behalf of County residents for the uninsured portion of the ambulance fee. Columbus, Ohio, has adopted an ordinance that appears to be structured in this way, and the Executive's proposed amendments would restructure the County's fee along the lines of the Columbus model.

- Does the disparity in treatment between residents and non-residents violate the equal protection guarantees of the United States Constitution and the Maryland Declaration of Rights?

The Deputy County Attorney found that imposing a higher EMST fee on non-residents does not violate either equal protection guarantee so long as the disparate treatment is based on a reasonable rationale. No amendments were recommended in connection with this issue.

On September 16, the Executive transmitted amendments to the Bill that would:

1) impose an EMST fee on everyone who is transported by ambulance, subject to a hardship waiver;
2) provide that the tax revenues received by the County are treated as payment on behalf of County residents of the balance of each resident's portion of the EMST fee that is not covered by the resident's insurance; and
3) require the Council annually to appropriate from the General Fund to the Consolidated Fire Tax District Fund an amount necessary to cover the liability for the balance of the EMST fees owed by all residents that the Council estimates will not be covered by residents' insurance.

The amended bill is attached on © 1-4. The Executive's transmittal memo is on © 4a-4b.

Questions from the Public and the Council

During the Council's review of the EMST fee, Councilmembers and the public raised several questions. For the July 24 Committee worksession, Executive staff provided preliminary responses to several questions that were raised during the public hearing. For this worksession, Executive staff provided written responses to those questions and others that were raised in correspondence from the public (see © 27-50).

Committee Worksession

For this worksession, Council staff suggests that the Committee:

- ask Executive staff to discuss the County Attorney's opinion and the rationale for the amendments proposed;
- ask Executive staff to walk through their responses to Council questions;
- consider whether any more information is needed or whether any unresolved issues must be addressed; for example, any arrangements to distribute a portion of the fee revenues to the LFRDs, or questions about the Fiscal Impact Statement; and
- consider what the Committee's next steps in reviewing this fee should be.

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Bill No. 25-08
Concerning: Emergency Medical Services Transport Fee – Imposition
Revised: 9-22-08 Draft No. 3
Introduced: June 10, 2008
Expires: December 10, 2009
Enacted: _____
Executive: _____
Effective: _____
Sunset Date: None
Ch. _____, Laws of Mont. Co. _____

COUNTY COUNCIL
FOR MONTGOMERY COUNTY, MARYLAND

By: Council President at the request of the County Executive

AN ACT to:

(1) authorize the [[Fire and Rescue Service]] County to impose and collect a fee to recover costs generated by providing emergency medical service transports;
(2) provide for a schedule of emergency medical services transport fees, fee waiver criteria, permitted uses of fee revenues, and other procedures to operate the emergency medical services fee program;
(3) prohibit a Local Fire and Rescue Department from imposing a separate emergency medical services transport fee;
(4) require the Executive to issue certain regulations to implement an emergency medical services transport fee;
(5) require a certain annual appropriation be made as payment of residents' uninsured portion of the emergency medical services transport fee; and
[[(5)]] (6) generally amend County law regarding the provision of emergency medical services.

By adding
Montgomery County Code
Chapter 21, Fire and Rescue Service
Section 21-23A

Boldface	*Heading or defined term.*
Underlining	*Added to existing law by original bill.*
[Single boldface brackets]	*Deleted from existing law by original bill.*
Double underlining	*Added by amendment.*
[[Double boldface brackets]]	*Deleted from existing law or the bill by amendment.*
* * *	*Existing law unaffected by bill.*

The County Council for Montgomery County, Maryland approves the following Act:

Sec. 1. Section 21-23A is added as follows:

21-23A Emergency Medical Services Transport Fee.

(a) Definitions.

In this section the following terms have the meanings indicated:

(1) Emergency medical services transport means the transportation by the Fire and Rescue Service of an individual by ambulance. Emergency medical services transport does not include the transportation of an individual under an agreement between the County and a health care facility.

(2) Federal poverty guidelines means the applicable health care poverty guidelines published in the Federal Register or otherwise issued by the federal Department of Health and Human Services.

(3) Fire and Rescue Service includes each local fire and rescue department.

(b) Imposition of fee. The **[[**Fire and Rescue Service**]]** County must impose a fee for any emergency medical service transport provided in the County and, unless prohibited, outside the County under a mutual aid agreement.

(c) Liability for fee.

[[(1) A County resident is responsible for the payment of the emergency medical services transport fee only to the extent of the resident's available insurance coverage.

(2) Subject to subsection (d), all other individuals are responsible for payment of the emergency medical services transport fee without regard to insurance coverage.**]]**

Subject to subsection (d), each individual who receives an emergency medical services transport is responsible for payment of the emergency

medical services transport fee.

(d) Hardship waiver.

(1) The Fire Chief must waive the emergency medical services transport fee for any individual who is indigent under the federal poverty guidelines. An individual must request a waiver on a form approved by the Fire Chief.

(2) The Fire Chief may deny a request for a waiver if the individual who claims financial hardship under this Section does not furnish all information required by the Fire Chief.

(e) **Payment of Residents' Uninsured Portion of the Emergency Medical Services Transport Fee.**

(1) Tax revenues received by the County must be deemed as payment, on behalf of residents of the County, of the balance of each resident's portion of the emergency medical services transport fee that is not covered by the resident's insurance.

(2) The County Council must annually appropriate from the General Fund to the Consolidated Fire Tax District Fund an amount that the Council estimates will not be covered by residents' insurance as payment of all residents' uninsured portion of the emergency medical services transport fee.

[[(e)]] (f) Obligation to transport. The Fire and Rescue Service must provide emergency medical services transport to each individual without regard to the individual's ability to pay.

[[(f)]] (g) Restriction on Local Fire and Rescue Departments. A local fire and rescue department must not impose a separate fee for an emergency medical transport.

[[(g)]] (h) Use of revenue. [[The]] Except for the appropriation received from

the General Fund under subjection (e), the revenues collected from the emergency medical services transport fee must be used to supplement, and must not supplant, existing expenditures for emergency medical services and other related fire and rescue services provided by the Fire and Rescue Service.

[[(h)]] (i) Regulations; fee schedule. The County Executive must adopt a regulation under method (2) to implement the emergency medical service transport fee program. The regulation must establish a fee schedule based on the cost of providing emergency medical services transport. The fee schedule may include an annual automatic adjustment based on inflation, as measured by an index reasonably related to the cost of providing emergency medical services transports. The regulation may require individuals who receive an emergency medical services transport to provide financial information, including the individual's insurance coverage, and to assign insurance benefits to the County.

Approved:

Michael J. Knapp, President, County Council Date

Approved:

Isiah Leggett, County Executive Date

This is a correct copy of Council action.

Linda M. Lauer, Clerk of the Council Date

BILL 25-08

037866

M.F.
C.C.
S.B.P.
L.L.
M.D.

OFFICE OF THE COUNTY EXECUTIVE
ROCKVILLE, MARYLAND 20850

Isiah Leggett
County Executive

MEMORANDUM

September 16, 2008

TO: Michael J. Knapp, President
County Council

FROM: Isiah Leggett, County Executive

SUBJECT: Bill 25-08, Emergency Medical Services Transport Fee - Amendments

I am transmitting for Council consideration amendments to Bill 25-08, Emergency Medical Services Transport Fee – Imposition.

As introduced, Bill 25-08 provides that each County resident would be responsible for the Emergency Medical Services Transport (EMST) fee only to the extent of the resident's available insurance coverage. The underlying reason for this provision was to credit residents for the taxes paid by residents to the County—thereby more equitably distributing the economic burden of providing ambulance service in the County between residents and nonresidents. These amendments make this underlying rationale explicit.

These amendments are modeled on an EMST fee ordinance recently enacted by Columbus, Ohio, and are consistent with the County Attorney's opinion reviewing the "insurance only" provision of Bill 25-08.

Specifically, these amendments: (1) impose an EMST fee on all individuals who are transported by ambulance, subject to a hardship waiver; (2) provide that the tax revenues received by the County are deemed as payment, on behalf of County residents, of the balance of each resident's portion of the EMST fee that is not covered by the resident's insurance; and (3) require the Council annually to appropriate from the General Fund to the Consolidated Fire Tax District Fund an amount necessary to cover the liability for the balance of the EMST fees owed by all residents that the Council estimates will not be covered by residents' insurance.

Executive staff will be available to work with Council on this vital legislation and to further explain the reasons underlying these proposed amendments.

IL:tjs

Attachment

cc: Tom Carr, Chief, Montgomery County Fire & Rescue Service
Joseph Beach, Director, Office of Management and Budget
Leon Rodriguez, County Attorney
Kathleen Boucher, Assistant Chief Administrative Officer
Marc Hansen, Deputy County Attorney

OFFICE OF THE COUNTY ATTORNEY

Isiah Leggett
County Executive

Leon Rodriguez
County Attorney

MEMORANDUM

TO: Phil Andrews, Chair
Public Safety Committee

VIA: Leon Rodriguez
County Attorney

FROM: Marc P. Hansen
Deputy County Attorney

DATE: September 12, 2008

RE: Bill 25-08; Ambulance Fees – Health Insurance Reimbursement – Equal Protection

Questions

Bill 25-08, Emergency Medical Services Transport Fee – Imposition, provides that a County resident is responsible for payment of the emergency medical services transport fee (ambulance fee) "only to the extent of the resident's available insurance coverage."[1] The Council has been provided with a copy of a letter from the Government Employees Health Association, Inc. (GEHA), indicating that GEHA would deny a claim for payment of the ambulance fee proposed by Bill 25-08, because GEHA "will not cover services or supplies for which no charge would be made if the covered individual had no health insurance coverage." Council staff has asked if the "insurance only provision" of Bill 25-08 provides a legal basis for health insurance carriers to deny payment of the County's proposed ambulance fee.

Bill 25-08 also provides that individuals who are not residents of Montgomery County must pay the ambulance fee without regard to insurance coverage.[2] Hence, non-residents will be responsible, in many cases, for paying a larger proportion of the ambulance fee than resident users of the ambulance service. Council staff has asked if this disparity in treatment between residents and non-residents violates the equal protection guarantees of the United States Constitution and the Maryland Declaration of Rights.

[1] § 21-23A (c) (1), lines 19-21.
[2] § 21-23A (c) (2), lines 22-24.

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Short Answers

Under the "insurance only provision" of Bill 25-08, a resident incurs no personal liability for the County's ambulance fee. Therefore, in many, if not most cases, private health insurance carriers would have a legal basis for refusing to pay a claim for payment of the ambulance fee.[3]

The Council, however, could amend Bill 25-08 to impose a fee on all ambulance users, but provide that taxes collected by the County will be deemed as payment on behalf of County residents of the uninsured portion of the ambulance fee. Amending Bill 25-08 in this manner would give Montgomery County a legal basis for insisting that health insurance carriers must pay the County's ambulance fee.

Imposing a higher ambulance fee on non-residents does not violate the equal protection guarantees of the United States Constitution or the Maryland Declaration of Rights so long as the disparate treatment rests on a reasonable rationale. By imposing a higher ambulance fee on non-residents, Bill 25-08 advances the reasonable legislative goal of more fairly distributing the cost of providing ambulance service within the County between residents who pay taxes to the County and non-residents.

Discussion

Heath Insurance – Liability for Ambulance Fee.

"Broadly speaking, health insurance is an undertaking by one person for reasons satisfactory to him to indemnify another for losses caused by illness." *Haines v. United States*, 353 U.S. 81, 83 (1957). "A medical expenses indemnity contract is an 'indemnity' contract, i.e., one which insured the subscriber against **actual** expense. On the other hand, an accident policy is not an indemnity contract and benefits may be due thereunder even though no actual **loss** has been incurred." (Emphasis in original) *Shapira v. United Medical Service, Inc., et al.*, 15 NY2d 200, 218-19 (1965).

In *Shapira*, a physician sought reimbursement for services provided to patients in a ward of a New York City municipal hospital. The court concluded that United Medical Service, Inc., a non-profit medical indemnity corporation, had no liability to the physician, because the patients treated were not liable for the services rendered—therefore, United Medical Service had no responsibility to compensate the physician.

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[3] This opinion does not address reimbursement from federal health care programs like Medicare. Federal health care programs reimburse local jurisdictions for ambulance fees even though the ambulance fee is imposed on residents only to the extent of their insurance coverage. This approval appears to be based on the rationale that local taxes may be deemed as payment on behalf of residents of the uninsured portion of an ambulance fee. In a July 20, 2001, opinion, the Office of the Inspector General for the Department of Health and Human Services concluded that a fire district's proposed ordinance that "only requires residents to pay to the extent of their insurance coverage (i.e., "insurance only" billing) and treats the operating revenues received from local taxes as payment of any otherwise applicable co-payments and deductibles due from the residents" would not violate the anti-kickback statute under federal law.

Other cases support the premise articulated in *Shapira*. In *Dillione v. Deborah Hospital, et al.*, 113 N.J. Super. 548 (1971), Alfred Dillione had open-heart surgery at the Deborah Hospital. Dillione was covered under a group health insurance policy issued by The Traveler's Insurance Company. The Traveler's Insurance Policy contained an exclusion from coverage that provided, "in no event will the employee's benefit be payable . . . for any . . . services or supplies . . . for which the employee incurred no expense." *Id.* at 551. The court noted:

> Where, however, the holder of a policy covering "expense incurred" for hospital charges received free care at a United States Veterans Hospital for which by federal law the hospital could make no charge against him, the holding was that since the plaintiff was **entitled** to free treatment, he had incurred no expense and was therefore not entitled to recover on the policy. (Emphasis in original) (Citations omitted)

Id. at 554-55.

The *Dillione* court concluded that the matter had to be remanded to the trial court because there was insufficient evidence in the record to determine if Dillione was primarily liable to the hospital for services rendered, whether or not sufficient insurance proceeds were available to cover the entire expense. The court stated

> If, on the other hand, Deborah's understanding with plaintiff, or with the Rehabilitation Commission on plaintiff's [Dillione's] behalf as a donee/beneficiary, was that plaintiff was under no circumstances to be liable to Deborah, the latter being content to resort solely to such rehabilitation or insurance moneys, if any, as might be available, plaintiff would have incurred no expense and Traveler's would not be liable.

Id. at 556.

Insurance in general, and health insurance in particular, is heavily regulated by the State of Maryland. Title 15 of the Maryland Insurance Code, consisting of nearly 250 pages of legislation, is devoted exclusively to the regulation of health insurance. In the instance of health insurance plans offered to the small employer market, State law actually requires that insurance carriers include the following coverage exclusion in their plans: "Services for which a covered person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan." COMAR 31.11.06.06 (2008).

A brief and somewhat random survey of individual health insurance plans offered in Maryland indicates that this exclusion required for health plans offered to small employers is commonly found in other plans. For example, one plan offered by CareFirst (Blue Cross/Blue Shield) provides, "Payment will not be made for services which, if the Member were not covered under the Group Contract, would have been provided without charge, including any charge or any portion of a charge which, by law, the provider is not permitted to bill or collect from the patient directly." Another CareFirst contract provides that payment will not be made, "for services without charge, including Medicaid, or where only insured persons are charged." Similar provisions appear in health insurance plans offered by United Healthcare and CeltiCare.[4]

Insurance carriers that include similar exclusions from coverage like that quoted from the CareFirst plan, will have a legal basis for refusing to pay Montgomery County's ambulance fee, because Bill 25-08 imposes no liability on residents for the ambulance fee. *Shapira v. United Medical Service, Inc.*

A different legal result, however, may obtain, if Bill 25-08 were amended to provide for imposition of the ambulance fee on all users but then provided that taxes collected from residents would be treated as payment of the residents' uninsured portion of the ambulance fee. If payment of taxes by resident was viewed as a collateral source of payment for the ambulance fee, a legal basis may be established for requiring private health insurance carriers to pay the County's ambulance fee on behalf of its insureds. In *Dillione v. Deborah Hospital*, the court noted

> The general rule is that the insured will not be barred from recovery on a policy providing for payment of hospital or medical services, etc., for which he has "insured expense" or similar language, by mere reason of the availability of collateral means of discharging his liability therefor so as to have relieved him of the need to pay the charges personally.

Id. at 554.

Columbus, Ohio, has adopted an ordinance that imposes an ambulance fee that appears to be premised on this collateral source of payment concept noted in *Dillione*. The Columbus ordinance treats taxes collected from residents as inuring to the benefit of resident users of the ambulance service. Section 1934.03 of the Columbus, Ohio, Code provides, "There is hereby established an emergency medical services reimbursement program which is incident to the provision of emergency medical services by the Division of Fire." Section 1934.04(a) provides "The Department of Public Safety shall establish fees for emergency medical services it renders to any person, whether a resident or non-resident of the City." Subsection (d) provides, "The cost of emergency medical care for a resident of the City that are not covered by private insurance or a public health care program **shall be deemed to be paid** from the operating

[4] See Attachment A.

revenues received by the City from local taxes and other sources." (Emphasis added)[5] According to an Assistant Columbus City attorney, private insurance carriers pay the City on behalf of their policy holders some portion of the ambulance fee imposed by the City.

Treating tax revenue as a source of prepayment of the uninsured portion of the ambulance fee incurred by a resident is comparable to the County providing each resident with a supplemental insurance policy--*i.e.* a collateral source of payment. As the *Dillione* court put it, "The mere fact . . . it was contemplated or expected that other sources would be available to defray the bill in whole or in part would not dissipate Traveler's liability for so much of the expenses plaintiff was primarily liable for." *Id.* at 556. See also, *Samsel v. Allstate Insurance Company*, 204 Ariz. 1, 59 P.3d 281 (2002) (Allstate Insurance Company required to reimburse its insured, Samsel, for hospital expenses even though the expenses had been paid by Samsel's health maintenance organization, because Allstate's insurance policy provided for payment of medical expenses "actually incurred" by its insured.) A similar result was reached by the Maryland Court of Appeals in *Dutta v. State Farm Insurance*, 363 Md. 540 (2001). In *Dutta*, the court concluded that State Farm Insurance was required to pay PIP (Personal Injury Protection) benefits to Dutta even though Dutta's hospital expenses were paid by his health maintenance organization.

Although there are no cases directly on point and so the matter is not free from doubt, amending Bill 25-08 to adopt an approach similar to the one used by Columbus would create a basis for imposing legal liability for the ambulance fee under most current private health insurance contracts. The County could reinforce the concept of tax revenues serving as a collateral source of payment for a resident's uninsured portion of the ambulance fee by annually appropriating from the general fund to the Consolidated Fire Tax District Fund an amount necessary to cover the liability for the balance of the fee owed by residents that the County estimates will not be covered by residents' insurance coverage.

Equal Protection

Bill 25-08 effectively imposes a greater burden on non-residents for the ambulance fee than is imposed on residents. Local governmental entities commonly impose higher user fees on non-residents *See*, for example, Montgomery County recreation fees ("Non-County residents must pay an additional $10 per participant, per activity."); Montgomery County Public School System tuition charge on non-residents ("All qualified school-aged individuals, whether U.S. citizens or non-citizens, who do not have an established *bona fide* residence in Montgomery County, will be considered non-resident students and will be subject to paying tuition unless an exception is made under the terms of this policy."); and Montgomery College tuition schedule, Code 3, which imposes higher tuition charges on non-residents than it imposes on resident students.[6] Nevertheless, any disparate treatment of individuals based on residency raises an equal protection issue under the United States Constitution and the Maryland Declaration of Rights.

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[5] A copy of the relevant portions of the Columbus Code are attached. See Attachment B.

[6] See Attachment C for information from the Montgomery County Department of Recreation, Montgomery County Public School System and Montgomery College.

Equal protection guarantees under the 14th Amendment of the United States Constitution and Article 24 of the Maryland Declaration of Rights are independent of each other. *Frankel v. Board of Regents of the University of Maryland System, et al.*, 361 Md. 298 (2000). Accordingly, each provision will be examined separately.

Federal courts have upheld imposing higher fees on non-residents in the face of 14th Amendment equal protection challenges. The United States Supreme Court approved Montana's imposition of a higher charge on non-residents to obtain a State elk-hunting license. *Baldwin, et al. v. Fish and Game Commission of Montana, et al.*, 436 U.S. 371 (1978). The Supreme Court noted that residents support the maintenance of big game in Montana by taxes, which support parks, game wardens, roadways, fire suppression, etc. "All this adds up, in our view, to no irrationality in the differences the Montana legislature has drawn in the costs of its licenses to hunt elk. The legislative choice was an economic means not unreasonably related to the preservation of a finite resource and a substantial regulatory interest of the State." *Id.* at 390. Although as the Court noted, the cost differential Montana imposed between resident and non-resident hunters might have been more precisely calculated, the Supreme Court nevertheless concluded, "a statutory classification impinging upon no fundamental interest . . . [that could] have furthered its underlying purpose more artfully, more directly, or more completely, does not warrant a conclusion that the method it choose was unconstitutional." *Id.* at 390.

More recently, the U.S. Court of Appeals for the First Circuit upheld the Town of Dartmouth's imposition of higher harbor fees on non-residents. *LCM Enterprises, Inc., et al., v. the Town of Dartmouth, et al.*, 14 F.3d 675 (1994). Finding that the disparate fee structure involved no suspect classification or impingement of a fundamental right, the Court applied the rational basis test to determine the constitutionality of the disparate treatment accorded non-residents:

> When a state, or political subdivision thereof, distinguishes between two similarly situated groups, the distinctions it makes are subject to scrutiny under the Equal Protection Clause of the Fourteenth Amendment. Such scrutiny is normally of the rational basis variety unless the distinction involves a suspect classification or burdens a fundamental right.
>
> * * *
>
> Under rational basis scrutiny, a classification will withstand a constitutional challenge as long as it is rationally related to a legitimate state interest and is neither arbitrary, unreasonable nor irrational.

Id. at 678-79.

Dartmouth asserted that its goal in imposing a disparate fee structure based on the residency of the user was to fairly distribute harbor costs among all users, thus equalizing the burden between residents and non-residents of maintaining the harbor. The Court agreed that this goal established a rational basis justifying disparate treatment between residents and non-residents, "if the record evidences any reasonable basis for Dartmouth to believe that there was a disparity in waterways contributions between residents and nonresidents." *Id.* at 680. The record in the case showed that Dartmouth spent all of the money received from harbor fees and, in addition, spent an even greater amount from the Town's general tax revenues to maintain the harbor. The Court concluded, "There is thus a disproportionate burden on residents for harbor expenses **even after the disparate fees are imposed**. Clearly, Dartmouth's attempt to make up some of this disparity through a disparate fee structure passes constitutional muster." (Emphasis in original) *Id.* at 681.

No Maryland case has directly considered the validity of imposing greater fees on non-residents in the context of an equal protection challenge under Article 24 of the Declaration of Rights—despite the apparent wide-spread practice of local jurisdictions in Maryland imposing higher user fees on non-residents. Although not directly on point, an examination of *Frankel v. Board of Regents of the University of Maryland* is instructive in analyzing the probable outcome of an equal protection challenge of the County's proposed ambulance fee under an Article 24 challenge. In this case, Jeremy Frankel challenged the manner in which the University of Maryland determined if a person was a resident. The court noted, "As the petitioner [Frankel] does not challenge the objective of according a reduced tuition benefit to *bona fide* Maryland residents, we shall assume that the Board's objective is entirely legitimate." *Id.* at 317. The court concluded that the method used by the University to determine residency status violated Article 24 because it imposed economic burdens tending to favor some Maryland residents over other Maryland residents. Thus, the court was deeply troubled that a *bona fide* Maryland resident would be treated as a non-resident. Although the court noted that it has been "particularly distrustful of classifications" that treat "residents of one county or city differently from residents of the remainder of the state", disparate treatment will be upheld if it rests on "some ground of difference having a fair and substantial relation to the object of the regulation." *Id.* at 316-17.

The ambulance fee proposed by Bill 25-8, which assigns a greater economic burden to non-residents is intended, like the harbor fee assessed by Dartmouth, to fairly distribute the burden of providing a governmental service between residents, who pay the taxes used to support the service, and non-residents. According to the Office of Management and Budget there is no question that County residents, as taxpayers, will continue to pay a disproportionate share of the cost of providing ambulance service in Montgomery County even after imposition of an ambulance fee. The Office of Management and Budget projects that revenues from ambulance fees as a percentage of the cost of providing ambulance service in the County will, in the first year, account for 23.8% of the cost; in the second year, 25.0%; in the third year, 26.2%; and in the fourth year, 27.4%. In light of this fact, the disparate treatment between residents and non-residents in the imposition of the County's ambulance fee rests, as the Court of Appeals put it in *Frankel*, on "some ground of difference having a fair and substantial relation to the object of the regulation."

I trust the Public Safety Committee will find this memorandum helpful in its consideration of Bill 25-08. If the Committee has any questions or concerns regarding this advice, please let me know.

cc: Thomas Carr, Chief, Montgomery County Fire & Rescue Services
Joseph Beach, Director, Office of Management & Budget
Kathleen Boucher, Assistant Chief Administrative Officer
✓ Michael Faden, Senior Legislative Counsel
Douglas Wolfberg, Special Counsel
Bernadette Lamson, Associate County Attorney
Scott Graham, Assistant Chief, Montgomery County Fire & Rescue Services

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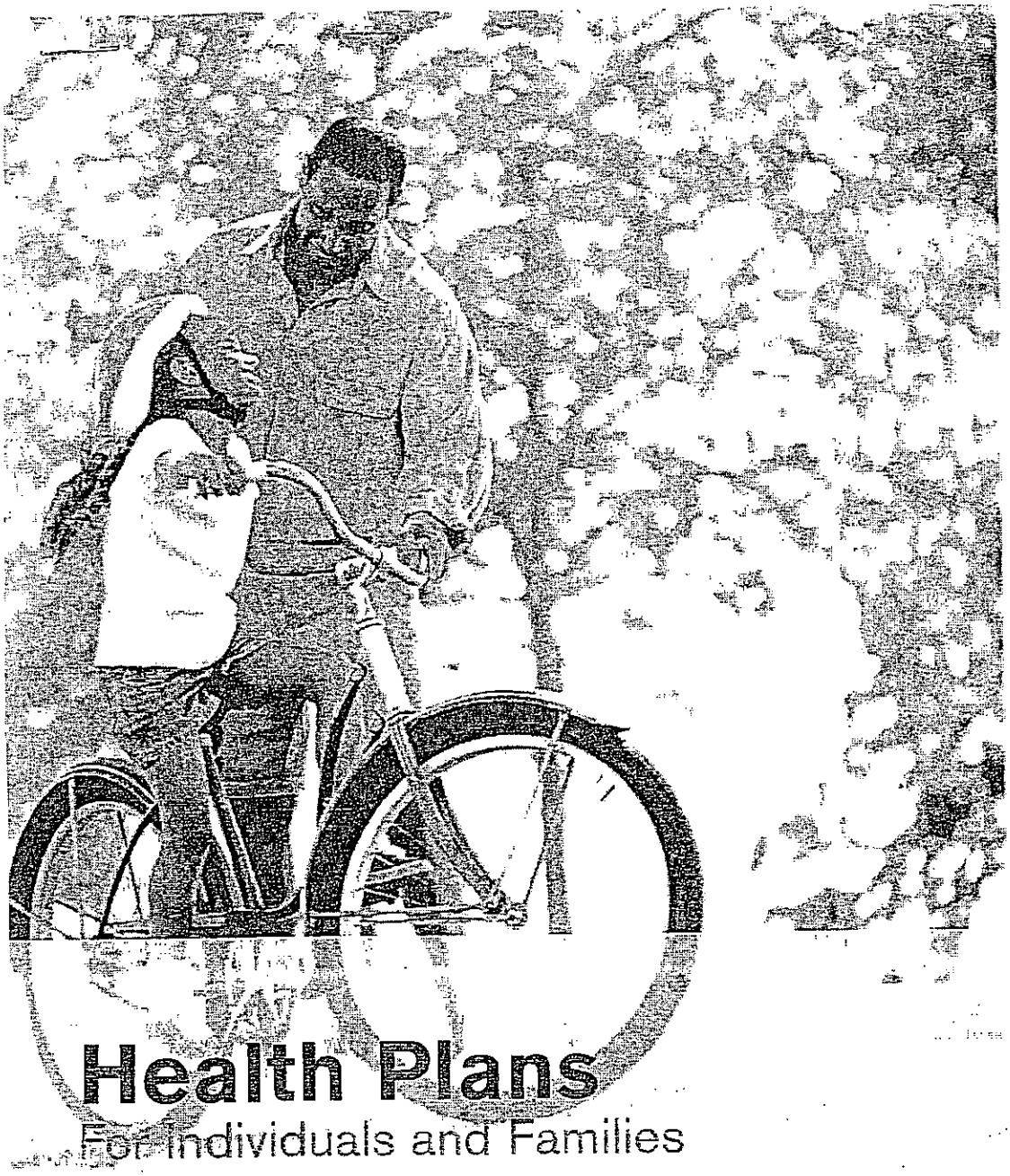

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Attachment A

General Exclusions

No benefits are payable for expenses which:

- Are due to pregnancy (except for complications of pregnancy) or routine newborn care (unless optional coverage is selected, if available).
- Are for routine or preventive care unless provided for in the policy.
- Are incurred while confined primarily for custodial, rehabilitative, or educational care or nursing services.
- Result from or in the course of employment for wage or profit, if the covered person is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a covered person's right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply.
- Are in relation to, or incurred in conjunction with, investigational treatment.
- Are for dental expenses or oral surgery, eyeglasses, contacts, eye refraction, hearing aids, or any examination or fitting related to these.
- Are for modification of the physical body, including breast reduction or augmentation.
- Are incurred for cosmetic or aesthetic reasons, such as weight modification or surgical treatment of obesity.
- Would not have been charged in the absence of insurance.
- Are for eye surgery to correct nearsightedness, farsightedness, or astigmatism.
- Result from war, intentionally self-inflicted bodily harm (whether sane or insane), or participation in a felony (whether or not charged).
- Are for treatment of temporomandibular joint disorders, except as may be provided for under covered expenses.
- Are incurred for animal-to-human organ transplants, artificial or mechanical organs, procurement or transportation of the organ or tissue, or the cost of keeping a donor alive.
- Are incurred for marriage, family, or child counseling.
- Are for recreational or vocational therapy or rehabilitation.
- Are incurred for services performed by an immediate family member.
- Are not specifically provided for in the policy or incurred while your certificate is not in force.
- Are for any drug treatment or procedure that promotes conception.
- Are for any procedure that prevents conception or childbirth.
- Result from intoxication, as defined by applicable state law in the state where the illness or injury occurred, or under the influence of illegal narcotics or controlled substances unless administered or prescribed by a doctor.
- Are for or related to surrogate parenting.
- Are for or related to treatment of hyperhidrosis (excessive sweating).
- Are for fetal reduction surgery.
- Are for alternative treatments, except as specifically identified as covered expenses under the policy/certificate, including: acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

Benefits will not be paid for services or supplies that are not medically necessary to the diagnosis or treatment of an illness or injury, as defined in the policy.

General Limitations

- Expenses incurred by a covered person for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs are not covered during the covered person's first six months of coverage under the policy. This provision will not apply if treatment is provided on an "emergency" basis. "Emergency" means a medical condition manifesting itself by acute signs or symptoms that could reasonably result in placing a person's life or limb in danger if medical attention is not provided within 24 hours.
- Covered expenses will not include more than what was determined to be the reasonable and customary charge for a service or supply.
- Transplants eligible for coverage under the Transplant Expense Benefit are limited to two transplants in a 10-year period.
- Charges for an assistant surgeon are limited to 20% of the primary surgeon's covered fee.
- Covered expenses for surgical treatment of TMJ, excluding tooth extractions, are limited to $10,000 per covered person.
- All diagnoses or treatments of mental disorders, as defined in the policy, including substance abuse, are limited to a lifetime maximum benefit of $3,000 (not covered in Saver Plans, subject to state variations). Covered expenses for outpatient diagnosis or treatment of mental disorders are further limited to $50 per visit. As with any other illness or injury, inpatient care that is primarily for educational or rehabilitative care is not covered.

The CELTICARE II Health Plan

Maryland

Comprehensive, flexible coverage

For kids, adults and families

CELTIC

Earning Your Trust, Every Day

deductible and coinsurance will apply. Drugs and medicines that are received after the first day of treatment for this bodily injury shall not be covered under this benefit.

Prescription Drug Option – Drugs with generic alternatives require the specified copay plus 100% of the cost difference between the drug and the generic alternative. Maintenance Drug prescriptions available by retail and mail order for a 90 day supply with a copay equal to 3x a one month supply.

Retail:

Generic

- No deductible
- $20 copay

Brand (Preferred and Nonpreferred/Specialty drugs)

- $100 annual deductible per person, per calendar year
- $40 copay for preferred drugs
- $75 copay for nonpreferred/specialty drugs

The following benefits are only available when a Preferred Provider Organization (PPO) plan is selected.

CELTICARE II [illegible] PPO PLAN

Network Physician Office Visits – Services performed by a network physician for a symptomatic insured person in an office setting are covered, subject to a $15 per visit copayment amount, up to six visits per person, per calendar year. The office visit covers only management and evaluation services and does not include labs and x-rays.

Non-network Services – The annual deductible is increased by $1,500 and an additional 20% coinsurance applies for all services received from an out-of-network provider (physician and/or hospital). This amount does not apply to the out-of-pocket maximum. Also, the office visit copay does not apply when non-network physicians are used.

CELTICARE II "ANY DOC" PPO PLAN

Physician Office Visits – Services performed by a physician for a symptomatic insured person in an office setting are covered, subject to a $35 per visit copayment amount, up to six visits per person, per calendar year. The office visit covers only management and evaluation services and does not include labs and x-rays.

Non-network Services – The annual deductible is increased by $1,500 and an additional 20% coinsurance applies for all services received from an out-of-network hospital. This amount does not apply to the out-of-pocket maximum.

If charges by a non-network hospital are incurred by an insured person due to a medical emergency, the annual deductible and coinsurance will be the same as if provided by a network hospital.

CELTICARE II HEALTH PLAN EXCLUSIONS

Benefits are not paid under any plan for a sickness or bodily injury resulting from:

- any act of war, declared or undeclared, or service in the military forces of any country, including non-military units supporting such forces;
- suicide or attempted suicide, or self-inflicted bodily injury while sane or insane;

No benefits are paid that are provided:

- free of charge in lieu of this insurance;
- by a government-operated hospital unless the insured person is required to pay;
- for treatment received outside the United States except for a medical emergency while traveling for up to a maximum of 90 consecutive days;

Additionally, no benefits are paid for:

- sickness or bodily injury that arises out of, or as a result of, any work if the insured person is required to be covered under Worker's Compensation or similar legislation.

Other exclusions include:

- tubal ligations and vasectomies performed while hospital confined are not covered. The reversal of a tubal ligation or vasectomy is not covered at any time;
- gender reassignment (sex change or reassignment);
- eye refractions, vision therapy, glasses or fitting of glasses, contact lenses, surgical or non-surgical treatment to correct refractive eye disorders, or any treatment or procedure to correct vision loss;
- hearing aids, exams or fittings, or surgical or non-surgical treatment or procedure to correct hearing loss;
- treatment or medication that is experimental or investigational;
- custodial care;
- myringotomy or dilation and curettage and surgical treatment of tonsils, adenoids or hernia within first 6 months of coverage;
- outpatient prescription drugs, unless purchased at a participating pharmacy;

IMPORTANT PLAN INFORMATION

Eligibility Requirements – To qualify for CeltiCare II coverage, a primary applicant must be six months or over and under $64\frac{1}{2}$ years of age and must not be covered under any other health insurance plan. Applicant must be a United States citizen or a foreign resident who has been living in the United States for at least two years under a permanent visa. Dependents must be 6 weeks or older.

Underwriting – Your CeltiCare II application is individually underwritten based on the health history of you and your dependents to be covered. To effectively underwrite your application, Celtic must obtain as much medical information about you as possible. This is accomplished through the use of health questions on the application form and, in some instances, a follow-up medical questionnaire and/or telephone verification of information. In addition, Celtic may request medical records as necessary.
If you answered "NO" to the five health questions on the application, have acceptable occupations/avocations, and are within the Company's height, weight, and age guidelines, your agent can get coverage instantly with QuikCoverage, if available in your state. Otherwise, please mail your application for underwriting.

Credit for Prior Deductibles – If you choose to replace current insurance coverage with the CeltiCare II Health Plan, you will receive credit for satisfying any portion of the previous carrier's deductible in the same calendar year. Copies of EOBs (Explanation of Benefits) are required for proof of deductible.

PLEASE NOTE: Creditable Coverage - Time spent under the CeltiCare II Health Plan may or may not count towards "creditable coverage" as defined in the Health Insurance Portability and Accountability Act, Public Law 104-191. Your individual circumstances, as well as state and federal law, will determine how much, if any, of your coverage under the CeltiCare II Health Plan is creditable coverage.

Pre-existing Conditions – A pre-existing condition is a sickness or bodily injury for which an insured person received a diagnosis, medical advice, consultation, or treatment during the 12 months prior to the effective date, or for which an insured person had symptoms 12 months before the effective date which would cause an ordinarily prudent person to seek medical care or treatment.

CeltiCare II will provide full coverage of pre-existing medical conditions if certain specific guidelines are met. The applicant must fully disclose all pre-existing medical conditions on the application. Then, if they pass our underwriting guidelines, on a standard basis, we'll provide full coverage. Benefits are not paid for an insured person's undisclosed pre-existing condition until coverage has been in force 12 months from the effective date provided coverage was issued on a standard basis.

When Coverage Begins and Ends – Your effective date will appear on the schedule page of your Policy, provided that you mail in your premium payment with your application and are accepted for coverage.
Coverage ends when:

- you fail to make the required premium payments;
- you cease to be an eligible dependent;
- you begin living outside the United States;
- you perform an act or practice that constitutes fraud;
- you have made an intentional misrepresentation of material fact under the Policy.

Celtic's Health Care Certification Program – Health Care Certification is a benefit which is automatically included in the CeltiCare II Health Plan. The Health Care Certification Program promotes high-quality medical care, and can help you better understand and evaluate your treatment options.

How does it work? – You need to contact the Celtic Health Care Certification Program at 1-800-477-7870 to certify medical treatment. The review team is made up of medical advisors with backgrounds in the medical, surgical, and psychiatric fields. If you have concerns about your proposed treatment, they can help you develop appropriate questions to ask your physician. The medical advisor may also discuss possible alternatives with your doctor if there are any questions regarding the necessity of your treatment. Celtic recommended second surgical opinions are always paid at 100%. Also, in the event of a non-certification there is an appeal process available.

Remember, the final decision for medical treatment is always the right and responsibility of you and your doctor.

What if I don't notify Celtic before treatment? – For all plans non-notification results in an exclusion from eligible expenses of 20% of all charges related to the treatment, if you did not notify the Celtic Health Care Certification Program before treatment.

What if my treatment is considered not medically appropriate and/or not medically necessary? – A "Notice of Non-Certification" is issued to you and your doctor. If you decide to receive the non-certified treatment, no benefits are paid.

[illegible]

The information shown in this brochure and in any accompanying literature is not intended to provide full details of Celtic plans and may change at the discretion of Celtic Insurance Company. Complete terms of coverage are outlined in the individual Policy Booklets. In applying for coverage, the primary insured agrees to be bound by the Policy.

Columbus, Ohio

Remove highlighting.

Title 19 POLICE AND FIRE DIVISIONS CODE

Chapter 1934 EMS REIMBURSEMENT FOR EMERGENCY MEDICAL SERVICES.

1934.01 Designation as primary provider.

The division of fire is the primary provider of pre-hospital emergency medical services within the corporate limits of the city and may provide such services outside the corporate limits of the city. All persons in need of such services are entitled to receive them without prior determination of their ability to pay. No person requiring emergency medical services shall be denied services due to lack of insurance or ability to pay. (Ord. 1183-02 § 1 (part).)

1934.02 Minimum level of care.

The city hereby mandates that all emergency medical service requests arising within the city through the 911 system or through any other means that an emergency call is received, be provided at the Advanced Life Support (ALS) level. (Ord. 1183-02 § 1 (part).)

1934.03 Program established.

There is hereby established an emergency medical services reimbursement program which is incident to the provision of emergency medical services by the division of fire. All policies governing this program shall be determined by the director of the department of public safety in collaboration with the director of the department of finance and management. (Ord. 1183-02 § 1 (part).)

1934.04 Fees.

(a) The department of public safety shall establish fees for emergency medical services it renders to any person, whether a resident or nonresident of the city. The fee shall reflect the costs of providing services for emergency care and shall include the costs of medical care plus the costs associated with transportation. Such fees, and any revisions to the fees, shall be approved by the director of the department of finance and management.
(b) When the division of fire renders emergency medical services to individuals, it shall inquire whether such individual is covered by any private or public health insurance plan, and, if the resident has coverage, the division shall attempt to make further inquiry to obtain the minimum data required to maintain accurate records and submit bills to the insurance carrier or public health care program, or to the patient's financially responsible party when required by law.
(c) The department of public safety is hereby authorized to enter into a contract with a third party

billing agency for the performance of emergency medical services billing and collection services. The department, or the authorized contractor, shall bill for such services within the timeframes established by department policy or by contract with a third party billing agency.
(d) The department of public safety, or the authorized contractor, shall collect from nonresidents of the city, those costs of emergency medical care that are not covered by their insurance carrier or public health care program. Such costs are limited to the insured's co-payment and/or coinsurance amounts as provided in the insured's coverage policy. The city will not balance bill when prohibited by law. In the event that a nonresident is uninsured, the department of public safety, or its designee, shall bill the nonresident for the full cost of services provided. The department may establish a hardship waiver determination policy to consider waiving the out-of-pocket financial obligations of nonresidents demonstrating a bona fide inability to pay. The costs of emergency medical care for a resident of the city that are not covered by private insurance or a public health care program shall be deemed to be paid from the operating revenues received by the city from local taxes and other sources.
(e) The department of public safety, or the authorized contractor, shall make reasonable efforts to collect amounts due from nonresidents of the city for the non-covered costs of care as outlined in subsection (d). (Ord. 1183-02 § 1 (part); Ord. 1102-05 § 1 (part).)

1934.05 Disposition of moneys.

All fees so collected by the department of public safety, or the authorized contractor, shall be deposited into the general fund. (Ord. 1183-02 § 1 (part).)

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MONTGOMERY MARYLAND
www.montgomerycountymd.gov

RECREATION DEPARTMENT

Programs Go!

Home | Information | Locations | Registration | Contacts | Survey

240-777-6840

Registration Information

Five Ways to Register

1 RecWeb Online registration is available for most classes listed in the Recreation Guide. Internet users must pay their account in full. For additional information, call 240-777-6840 or click here for an online tour.

2 STARline members may register by using our telephone automated registration system. If you are interested in becoming a STARline member, please fill in the application form. Allow two weeks for your STARline application to be processed. STARline users must pay their account in full. STARline registration number is 240-777-8277.

3 **Fax 240-777-6818** Faxed registrations must be paid by VISA or MasterCard. Due to high volume, we are unable to confirm receipt of faxes. To avoid duplication, do not mail your original form.

4 **Mail** Montgomery County Dept. of Recreation, Attention: Registrar, 4010 Randolph Road, Silver Spring, MD 20902-1099.

5 **Full Service** in-person registration is available at the following locations:

Administrative Offices 240-777-6840
4010 Randolph Road, Silver Spring
M-F 8:30am-5:00pm

Registration is also available at all Regional Service Centers.

Bethesda-Chevy Chase 301-983-4467
11315 Falls Road, Potomac

East County 240-777-4980
14906 Old Columbia Pike, Burtonsville

Mid-County 240-777-4930
4010 Randolph Road, Silver Spring

Silver Spring 240-777-4900
2450 Lyttonsville Road, Silver Spring

Upcounty 240-777-6940
12900 Middlebrook Road, Germantown

Registration Confirmation
Confirmations will be mailed as registrations are processed. If you do not receive your confirmation, call 240-777-6840. A waiting list notification will be sent to you if you do not get placed.

(19)

Attachment

Payment Information

1 Full payment must be made at time of registration. Do not submit registrations and/or payments to the instructor at the program. See Five Ways to Register.

2 Non-county residents must pay an additional $10.00 per participant per activity.

3 Make checks and money orders payable to MCRD. Checks and money orders must include name, address, home and work telephone numbers, driver's license number, and participant's full name. VISA or MasterCard payments are accepted. Registration form must include correct credit card number, expiration date, authorized signature, and authorized amount.

4 Financial Assistance is available to county residents who are recipients of assistance from other Montgomery County agencies. Eligibility is based on proof of that assistance. A financial assistance application form may be picked up at any recreation office, community center, or swim center. You may also obtain an application by calling 240-777-6840; or through the internet.

5 Payment plans are offered only for summer programs to county residents who cannot pay the full amount due at the time of registration. All payment plans must be paid in full by June 1. Please register early to take advantage of this payment option.

6 The Department of Recreation reserves the right to pursue all available options to collect any funds owed as the result of a dishonored check or credit card, charges incurred due to unsubstantiated credit card disputes, or any outstanding debt.

If your check is returned unpaid, your account will be debited electronically for the original check amount and electronically or via paper for the state's maximum allowable service fee. Payment by check constitutes authorization of these transactions. You may revoke your authorization by calling 800-666-5222 ext. 2 to arrange payment due for any outstanding checks and service fees due.

Withdrawal Policy

Registration form

Cancellation Policy

Administrative Office: 4010 Randolph Road, Silver Spring, MD 20902
Customer Service: Monday-Friday: 8:30am-5:00pm

POLICY BOARD OF EDUCATION OF MONTGOMERY COUNTY

Related Entries: JEA-RB, JEA-RC, JEA-RD, JED-RA, JEE, JEE-RA, KLA-RA
Responsible Office: Chief of Staff

Residency, Tuition, and Enrollment

A. PURPOSE

The Board of Education is committed to an effective, efficient, and equitable enrollment process for all eligible Montgomery County school-aged children.

B. ISSUE

All qualified school-aged individuals, whether U.S. citizens or noncitizens, who have an established bona fide residence in Montgomery County are to be admitted free to the Montgomery County Public Schools. There are circumstances that exist where students who are not residents of Montgomery County want or need to attend schools here; therefore, issues of residency and the processes for paying tuition must be clearly articulated.

C. POSITION

The Board of Education of Montgomery County supports the right of its residents to a free public education.

1. Bona fide residence is one's principal residence, maintained in good faith, and does not include a residence established for convenience or for the purpose of free school attendance in the Montgomery County Public Schools. However, an intent to reside indefinitely or permanently at the present place of residence is not necessarily required. Determination of a person's bona fide residence is a factual one and must be made on an individual basis.

2. All qualified school-aged individuals, whether U.S. citizens or noncitizens, who have an established bona fide residence in Montgomery County will be considered resident students and will be admitted free to the Montgomery County Public Schools.

3. All qualified school-aged individuals, whether U.S. citizens or noncitizens, who do not have an established bona fide residence in Montgomery County, will be

considered nonresident students and will be subject to paying tuition unless an exception is made under the terms of this policy.

a) A qualified student placed in a group home or foster home located in Montgomery County by an out-of-state agency other than those specified in Section 4-122 of the Education Article, *Annotated Code of Maryland*, shall be presumed to be a nonresident student.

b) In the absence of evidence to the contrary, a qualified student who is a resident of another educational jurisdiction, but who elects to seek enrollment in a Montgomery County public school shall be presumed to be a nonresident student.

c) In the absence of evidence to the contrary, the bona fide residence of a qualified student who is under 18 years of age and not emancipated shall be presumed to be the bona fide residence of both or one of the child's parents. Throughout this policy and any implementing regulations, if the parents live apart, use of the word "parent" shall mean (1) the parent to whom legal custody is awarded or (2) if legal custody is not awarded, the parent with whom the child regularly lives; and the child's bona fide residence shall be determined accordingly.

d) In the absence of evidence to the contrary, a qualified student residing with a court-appointed guardian who has an established bona fide residence in Montgomery County shall be presumed to be a resident student provided that the guardianship was obtained for reasons concerning the child and not for the primary purpose of attending school or for the convenience of the persons involved.

e) Qualified identified Montgomery County students who are homeless shall be enrolled in accordance with Regulation JEA-RD.

f) A qualified student placed in a group home or foster home in Montgomery County by social service agencies of the State of Maryland, or any other agency specified in Section 4-122 of the Education Article of the *Annotated Code of Maryland* shall be presumed to be a resident student for whom the Montgomery County Public Schools is eligible for reimbursement of actual educational expenses by another Local Educational Agency or the State of Maryland.

g) A qualified student who is a resident of Maryland residing in a valid kinship care arrangement pursuant to Section 4-122 of the Education Article of the *Annotated Code of Maryland* will be presumed to be a resident student for whom the Montgomery County Public Schools is eligible for reimbursement

of actual educational expenses by another local education agency or the State of Maryland.

4. The Residency Compliance Unit will make individual determinations of residency. Individual determinations of residency by the Residency Compliance Unit will be re-evaluated at least annually. The Residency Compliance Unit will make determinations in the following cases:

   a) There is evidence rebutting the presumption of residency or nonresidency set forth in Section 3

   b) When there is a qualified student who is 18 years of age or older and essentially self-supporting or an emancipated minor who may or may not have established a bona fide residence in Montgomery County without regard to the residency of the parents

   c) When there is a qualified student under 18 years of age who is living in Montgomery County with friends or relatives who are not parents or court-appointed guardians

   In addition to individual verification, MCPS reserves the right to initiate specific grade level or schoolwide residency verification activities. The burden of producing evidence establishing bona fide residence is on the student or individual acting on behalf of the student.

5. Admission of Nonresident Students

   a) Regardless of their willingness to pay tuition, nonresident students may be denied admission to the Montgomery County Public Schools.

   b) Except to the extent to which the implementing regulation provides for either a grace period or permits a deposit to be made during the pendancy of an appeal of a determination of nonresidency, before a nonresident student is enrolled in the Montgomery County Public Schools, tuition will be charged and paid unless a waiver is granted as provided below:

      (1) The nonresident student is residing in Montgomery County with a host family for a maximum of one year and has met the criteria established and detailed in MCPS Regulation JEA-RC, *Enrollment and Placement of International and Foreign Students,* including the approval by the supervisor of the International Student Admissions Office

(2) There is a crisis, unusual and extraordinary circumstances fully documented by the parent, guardian, or emancipated student, justifying waiver of tuition

c) Tuition rates will be established annually by the Board of Education upon the recommendation of the superintendent of schools.

d) A non-resident student applicant may request a specific school; however, MCPS reserves the right to determine the school of enrollment.

6. Responsibilities

a) Parents, guardians, or students who have reached the age of majority are responsible for signing an affidavit as to their bona fide residence or nonresidence in Montgomery County as a prerequisite to a student's initial enrollment in the Montgomery County Public Schools. Additionally, there is an acknowledgment that tuition will be paid for any period(s) of nonresidency, even if the period(s) of nonresidency should occur or be identified after the date of initial enrollment.

b) The school principal or designee (or the International Student Admissions Office for noncitizens who have not attended school within the United States at any time during the prior two years) is responsible for making the initial determination of the residency status of students who seek enrollment in a Montgomery County public school and, based on that determination, for taking the appropriate administrative steps specified in MCPS regulations.

c) The Residency Compliance Unit is responsible for determining the residency and tuition status of all students referred to it by the individual schools or the International Student Admission Office.

7. Appeals

Decisions made under this policy and any implementing regulations may be appealed under the provisions of Regulation KLA-RA: *Responding to Citizen Inquiries and Complaints From the Public*. The superintendent or a designee may assign a hearing officer to hear residency and tuition appeal cases on the superintendent's behalf and make recommendations to the superintendent or designee.

D. DESIRED OUTCOME

An effective, efficient, and equitable enrollment process which ensures the right of eligible students to a free public education and minimizes barriers for enrollment.

E. REVIEW AND REPORTING

1. The superintendent will provide a report to the Board of Education at least annually regarding the enrollment of nonresident students and tuition payments.

2. This policy will be reviewed in accordance with the Board of Education Policy BFA, *Policysetting*.

Policy History: Adopted by Resolution No. 366-87, July 14, 1987; amended by Resolution No. 65-92, January 27, 1992; amended by Resolution No. 328-04, June 8, 2004.

>> Tuition and Fee Schedule for Fall 2008

Printable Version

	COUNTY RESIDENT (CODE 1)						MD STATE RESIDENT (CODE 2)						
CR. HRS.	TUITION	CONS. FEE	FAC. FEE	TECH. FEE	TRANS. FEE	TOTAL	CR. HRS	TUITION	CONS. FEE	FAC. FEE	TECH. FEE	TRANS. FEE	TOTAL
1	99.00	50.00	5.00	5.00	4.00	163.00	1	203.00	50.00	5.00	5.00	4.00	267.00
2	198.00	50.00	10.00	10.00	8.00	276.00	2	406.00	81.20	10.00	10.00	8.00	515.20
3	297.00	59.40	15.00	15.00	12.00	398.40	3	609.00	121.80	15.00	15.00	12.00	772.80
4	396.00	79.20	20.00	20.00	16.00	531.20	4	812.00	162.40	20.00	20.00	16.00	1,030.40
5	495.00	99.00	25.00	25.00	20.00	664.00	5	1,015.00	203.00	25.00	25.00	20.00	1,288.00
6	594.00	118.80	30.00	30.00	24.00	796.80	6	1,218.00	243.60	30.00	30.00	24.00	1,545.60
7	693.00	138.60	35.00	35.00	28.00	929.60	7	1,421.00	284.20	35.00	35.00	28.00	1,803.20
8	792.00	158.40	40.00	40.00	32.00	1,062.40	8	1,624.00	324.80	40.00	40.00	32.00	2,060.80
9	891.00	178.20	45.00	45.00	36.00	1,195.20	9	1,827.00	365.40	45.00	45.00	36.00	2,318.40
10	990.00	198.00	50.00	50.00	40.00	1,328.00	10	2,030.00	406.00	50.00	50.00	40.00	2,576.00
11	1,089.00	217.80	55.00	55.00	44.00	1,460.80	11	2,233.00	446.60	55.00	55.00	44.00	2,833.60
12	1,188.00	237.60	60.00	60.00	48.00	1,593.60	12	2,436.00	487.20	60.00	60.00	48.00	3,091.20
13	1,287.00	257.40	65.00	65.00	52.00	1,726.40	13	2,639.00	527.80	65.00	65.00	52.00	3,348.80
14	1,386.00	277.20	70.00	70.00	56.00	1,859.20	14	2,842.00	568.40	70.00	70.00	56.00	3,606.40
15	1,485.00	297.00	75.00	75.00	60.00	1,992.00	15	3,045.00	609.00	75.00	75.00	60.00	3,864.00
16	1,584.00	316.80	80.00	80.00	64.00	2,124.80	16	3,248.00	649.60	80.00	80.00	64.00	4,121.60
17	1,683.00	336.60	85.00	85.00	68.00	2,257.60	17	3,451.00	690.20	85.00	85.00	68.00	4,379.20
18	1,782.00	356.40	90.00	90.00	72.00	2,390.40	18	3,654.00	730.80	90.00	90.00	72.00	4,636.80
19	1,881.00	376.20	95.00	95.00	76.00	2,523.20	19	3,857.00	771.40	95.00	95.00	76.00	4,894.40
20	1,980.00	396.00	100.00	100.00	80.00	2,656.00	20	4,060.00	812.00	100.00	100.00	80.00	5,152.00

	NON-RESIDENT (CODE 3)					
CR. HRS.	TUITION	CONS. FEE	FAC. FEE	TECH. FEE	TRANS. FEE	TOTAL
1	275.00	55.00	5.00	5.00	4.00	344.00
2	550.00	110.00	10.00	10.00	8.00	688.00
3	825.00	165.00	15.00	15.00	12.00	1,032.00
4	1,100.00	220.00	20.00	20.00	16.00	1,376.00
5	1,375.00	275.00	25.00	25.00	20.00	1,720.00
6	1,650.00	330.00	30.00	30.00	24.00	2,064.00
7	1,925.00	385.00	35.00	35.00	28.00	2,408.00
8	2,200.00	440.00	40.00	40.00	32.00	2,752.00
9	2,475.00	495.00	45.00	45.00	36.00	3,096.00
10	2,750.00	550.00	50.00	50.00	40.00	3,440.00
11	3,025.00	605.00	55.00	55.00	44.00	3,784.00
12	3,300.00	660.00	60.00	60.00	48.00	4,128.00
13	3,575.00	715.00	65.00	65.00	52.00	4,472.00
14	3,850.00	770.00	70.00	70.00	56.00	4,816.00
15	4,125.00	825.00	75.00	75.00	60.00	5,160.00
16	4,400.00	880.00	80.00	80.00	64.00	5,504.00
17	4,675.00	935.00	85.00	85.00	68.00	5,848.00
18	4,950.00	990.00	90.00	90.00	72.00	6,192.00
19	5,225.00	1,045.00	95.00	95.00	76.00	6,536.00
20	5,500.00	1,100.00	100.00	100.00	80.00	6,880.00

CONSOLIDATED FEE (CONS. FEE)
20% of total tuition with a minimum of $50.00 (not to exceed 20% of maximum tuition charge for each resident code). Fee is non-refundable after the first week of classes.

MAJOR FACILITY FEE (FAC. FEE)
This fee is assessed at $5 per credit hour to fund capital facilities. No maximum hours. (Nonrefundable fee)

SPECIAL NOTE
Effective April 17, 1995, by action of the BOT the tuition cap has been eliminated. This schedule shows through 20 hours only in order to provide a guide.

TECHNOLOGY FEE (TECH. FEE)
This fee is assessed to partially offset the costs of technology associated with instructional programs. (Nonrefundable fee)

OFFICE OF THE COUNTY EXECUTIVE

Isiah Leggett
County Executive

Timothy L. Firestine
Chief Administrative Officer

MEMORANDUM

September 23, 2008

TO: Michael Faden, Senior Legislative Attorney
Minna Davidson, Legislative Analyst
Montgomery County Council

FROM: Kathleen Boucher, Assistant Chief Administrative Officer KWB
Office of the County Executive

SUBJECT: Bill 25-08, Emergency Medical Services Transport Fee – Imposition

I am forwarding responses to your questions regarding Bill 25-08, Emergency Medical Services Transport Fee – Imposition that were included in: (1) the Council staff packet for the July 24 Public Safety Committee worksession; and (2) email messages dated August 7, August 12, September 10, and September 17. Please let me know if you have any additional questions.

I. Council Staff Packet for July 24 Public Safety Committee Worksession

Question 1

How many refusals for EMS transport were filed per year before Fairfax passed their law, and how many were filed after? Please provide the same information for Frederick and Howard Counties.

Answer

MCFRS contacted Frederick County and Fairfax County and asked for this information. Frederick County advised MCFRS that it did not gather patient refusal information. Fairfax County responded with the total number of individuals who received treatment without transport in FY06 (7706), FY07 (8361), and FY08 (8061). MCFRS was advised that the total number of calls in Fairfax County increased each year and the increase in the number of individuals treated without transport was proportionate to those overall increases. Howard County does not yet have an EMST fee.

Question 2

In public hearing testimony, John Bentivoglio cited two journal articles that indicated that economic concerns might influence a patient's decision regarding the use of EMS service. Please explain Executive staff's understanding of the findings in these articles, and the extent to which the findings indicate that charging an EMST fee might discourage individuals from calling 911 in a medical emergency.

Answer

The two journal articles cited by Mr. Bentivoglio do not support the proposition that the implementing an EMST fee would decrease EMS utilization in an emergency. In fact, one study specifically noted that "statistical significance could not be attributed to a prepayment effect. This variable should be interpreted with some care." The study went on to conclude that these issues "need to be analyzed further to determine if [payment systems] represent a major factor among patients when evaluating options for emergency transportation."

Mr. Bentivoglio cited the June 2000 article entitled "*Association Between Prepayment Systems and EMS Use Among Patients With Acute Chest Discomfort Syndrome*" for the proposition that "economic factors may affect EMS system usage". He omitted references to the parts of the article where the authors make it clear that they were not necessarily referring to EMS fees. The authors also concluded that there are a multitude of other "unmeasured community factors" that may influence the decision to use EMS. For instance, the number of hospitals, differences in medical care systems, public education and promotion of the EMS system, and many other factors, go into a person's decision to use EMS. In addition, a patient who lacks financial means may decide not to call 911 *not* because of a possible ambulance bill, which he or she may not even be aware of, but because of the certainty of much more sizable bills from the hospital, the doctor and others in the health care system. In fact, this study cites another study which concluded that the uninsured are 9 times more likely to delay seeking care. That is not the result of the presence of absence of an EMST fee; it has to do with the broader health care system. This study also found that low-income users were 2.6 times as likely to use EMS when "prepayment" system was in place. Montgomery County is proposing just such a system: where County tax revenues would "prepay" any out-of-pocket liability for County residents, who constitute the vast majority of system users. The study found that low-income residents without insurance were 3.87 times more likely to use EMS when a "prepayment" system was in place. This study could be cited to support the proposition that EMS usage could be expected to increase among County residents if Bill 25-08 is enacted, because County tax revenues will constitute "prepayment" of their out-of-pocket expenses.

© 51-56

The second study, the July 11, 2000 article entitled "*Demographic, Belief and Situational Factors Influencing the Decision to Utilize EMS Among Chest Pain Patients,*" also

© 57-71

references data from "prepayment" systems (i.e., "subscription" programs) where the user is indemnified for the cost of out-of-pocket expenses (such as co-payments). Among these types of users, the study concluded that "prepayment" systems increased EMS use, especially among lower income populations. This study could also be cited for the proposition that EMS use by County residents could be expected to increase under the County's tax-supported prepayment plan, especially among low-income users.

Question 3

William Sullivan provided a letter from the Government Employees Health Association (GEHA) stating that GEHA would deny a claim for a Montgomery County EMST fee because of a specific exclusion that states that GEHA will not cover services or supplies for which no charge would be made if the covered individual had no health insurance. Other insurance programs contain similar exclusions. What would be the impact of this type of exclusion on the County's EMST fee as currently proposed?

Answer

Under Bill 25-08, each County resident would be responsible for the EMST fee only to the extent of the resident's available insurance coverage. The underlying reason for that component of the bill was to credit County residents for the taxes they pay to the County; thereby more equitably distributing the economic burden of providing EMST services in the County between residents and non-residents. The County Executive recently proposed that Bill 25-08 be amended to make more explicit the underlying rationale for the distinction between residents and nonresidents. Those amendments are modeled after a law recently enacted by Columbus, Ohio and are consistent with the County Attorney's opinion reviewing the "insurance only" provision of Bill 25-08.

Question 4

Are Fairfax/Frederick/Howard able to collect an EMST fee from federal workers insured by GEHA? If so, how are their processes different from the Executive's proposal?

Answer

We have been advised that Fairfax County and Frederick County that no private insurers have refused to pay claims for EMST fees. The enabling law for those jurisdictions are different from Bill 25-08 because they impose the EMST fee on residents and nonresidents in the same manner, with both being held legally responsible for co-pays and deductibles or, in the case of uninsured individuals, for the EMST fee.

Question 5

Please provide drafts of any correspondence, statements, or forms that would be sent to uninsured Montgomery County residents under the proposed EMST fee.

Answer

Under Bill 25-08, an uninsured resident will not be responsible for the EMST Fee. Uninsured residents may receive a written document requesting information about insurance coverage. The exact document which would be sent to uninsured residents will not be developed until after the bill is enacted and a billing vendor is retained. However, we envision that an uninsured resident would receive a document that is similar to the Request for Insurance Information used by Columbus, Ohio (see **Attachment 1**).

Question 6

Please provide drafts of the same documents, but for non-residents.

Answer

Under Bill 25-08, an uninsured non-resident would be responsible for the EMST Fee unless the patient is eligible for a hardship waiver. An uninsured non-resident may apply for a hardship waiver of the EMST fee. The exact documents that would be used by uninsured non-residents to apply for a hardship waiver will not be developed until after the bill is enacted and a billing vendor is retained.

Question 7

Please provide copies of Fairfax County's correspondence and waiver form for uninsured individuals.

Answer

A copy of the waiver form used by Fairfax County is attached as **Appendix 2**.

Question 8

How many residents have filed for an EMST fee waiver in Fairfax in each year since the fee was imposed?

Answer

In the first year of implementation (which ended March 31, 2006), Fairfax County received and approved 353 hardship waivers (totaling $140,502). We do not have data for subsequent years. As noted in the Answer to Question 4 in this section, the Fairfax County enabling law is different from Bill 25-08 because it imposes the EMST fee on residents and nonresidents in the same manner, with both being held legally responsible for co-pays and deductibles or, in the case of uninsured individuals, for the EMST fee.

Question 9

The Council received an e-mail from Erin Gilland Roby which said that if the County charges an EMST fee, immunity from lawsuits will end for career and volunteer personnel. Does the County Attorney agree with this interpretation?

Answer

In 1983 the Maryland General Assembly passed the Fire-Rescue Immunity Act, currently codified in §5-604 of the Courts and Judicial Proceedings Article. That law grants immunity to individuals who provide fire-rescue services without regard to whether or not a fee is charged for the service. In the case of *Baltimore City v. Chase,* 360 Md. 121 (Md. 2000), the Court of Appeals expressly ruled that the immunity granted under §5-604 applied to a fire department (Baltimore City) which charges a fee for services.

Question 10

If so, what are the implications for the County and for career and volunteer fire and rescue personnel?

Answer

See Answer to Question 9 in this section.

Question 11

If not, what is the County Attorney's understanding about the impact of an EMST fee on protections under the Good Samaritan law?

Answer

See Answer to Question 9 in this section.

Question 12

The representative from the Wheaton Volunteer Rescue Squad testified that their charter does not permit them to charge a fee. Do other LFRD charters prohibit charging fees? How does the Executive's proposed EMST fee reconcile with LFRD charter prohibitions against charging fees?

Answer

Under Bill 25-08, the County is the billing entity, not the LFRDs. There is no legal conflict between Bill 25-08 and the provisions of any LFRD charter.

Question 13

Do Fairfax/Frederick/Howard volunteer fire and rescue departments have any information on fundraising before and after the imposition of EMST fees?

Answer

We were advised by a representative of the Fairfax Volunteer Fire and Rescue Association (FVFRA) that volunteer fire companies did not experience a drop in fund raising that could be attributed to imposition of an EMST fee (see **Attachment 3.**). Likewise, we were advised by the Frederick County Volunteer Fire and Rescue Association that the imposition of an EMST fee had no "measurable affect" on fundraising efforts of volunteer fire companies. Howard County does not yet have an EMST fee (see **Attachment 4**).

Question 14

If a patient has private insurance in addition to Medicare, does the private insurance pay the excess over any Medicare reimbursement for EMS transport?

Answer

The answer to this question depends on the type of private insurance. Most Medicare Part B beneficiaries carry supplemental (Medigap) insurance. This type of insurance covers beneficiary cost-sharing obligations (e.g., co-pays and deductibles). Some Medicare beneficiaries also have other health insurance (e.g., through employers). In those cases, private insurance may be primary to Medicare (e.g., if a Medicare beneficiary is injured at work, workers' compensation insurance may be the primary payor and Medicare the secondary payor).

Question 15

If a patient is covered under more than one group or private insurance plan, does the secondary insurance pay the excess over any primary insurance reimbursement for EMS transport?

Answer

It depends on the type of coverage. Typically, a primary plan covers the EMST fee, minus any applicable co-pay or deductible, and a secondary or supplemental plan would cover the co-pay or deductible. In many cases, those secondary balances automatically "cross over" from the primary payer to the secondary payer. In other cases, the billing company must send an Explanation of Benefits (EOB) from the primary insurer to the secondary insurer along with a claim for the balance.

Question 16

How will the County (or a third party administrator) coordinate with hospitals to collect billing information? Will the procedures be the same for each hospital? If not, how much will the procedures have to be adjusted for each hospital?

Answer

This is typically done via electronic interface, and some billing companies have established sophisticated linkages for this to occur. MCFRS anticipates that this process will be very similar for all hospitals.

II. Email Message – August 7, 2008

Question 1

Since Kaiser will not pay for a service which they have not pre-approved, what is their policy about paying for ambulance service?

Answer

We have been advised by Kaiser Permanente (Kaiser) representatives that emergency services to do not require pre-approval. Emergency transport is a covered expense and generally requires only that the transport be to the nearest hospital (see **Attachment 5**).

Question 2

What is Kaiser's policy about paying for ambulance service for members who are also covered by Medicare?

Answer

Medicare is the primary payor and Kaiser is the secondary payor (see **Attachment 5**). Kaiser has two products that it offers to Medicare eligible members: (1) a Medicare Cost Plan; and (2) a Medicare Plus Plan. The Medicare Cost Plan covers the emergency transport and then Kaiser coordinates with Medicare to get reimbursement for the expense. The Medicare Plus Plan is set up to coordinate with Medicare by actually becoming the Medicare plan and results from a three-way agreement between the member, Kaiser, and Medicare. It is seamless to the member and for billing, but the coordination works differently behind the scenes. _

III. Email Message – August 12, 2008

Question 1

If an EMST fee is charged, what service will County residents get that they are not currently getting?

Answer

On May 13, 2008, the County Executive submitted an Implementation Plan to Council which outlined the projected uses of the EMST fee revenues. As outlined in that plan, the demand for EMST response has been growing significantly for the past several years as the County has grown, especially in the Upcounty area. To respond to these services demands, improve response time, and enhance firefighter/rescue officer safety, several enhancements have been initiated within MCFRS and will require additional funding in the future, including: (1) implementing 4-person staffing (the County has initiated the first two phases of a seven-phase plan; (2) staffing for new stations in the Upcountry area, including Travilah, West Germantown, East Germantown, and Clarksburg; (3) implementing the Apparatus Management Plan that will replace, upgrade, and modernize apparatus, and provide additional maintenance staff, supplies, and facilities; (4) implementing the State required Electronic Patient Care Reporting System (e-PCR); and (5) supporting LFRDs by funding on-going station maintenance and other needs. We project that these service enhancements would cost approximately $19 million in FY10, $24 million in FY11, and $33 million in FY13.

Question 2

Consolidated Fire Tax District revenues have been greater than expenditures in each recent fiscal year, and are projected to be greater than expenditures in FY09. Why are there excess revenues? Why can't the County spend all of the money in the Consolidated Fire Tax District fund each year and avoid charging an EMST fee?

Answer

The revenues in the Consolidated Fire Tax District (CFTD) that exceed expenditures are not "excess revenues". They are a prudent reserve that is maintained for the CFTD, as is done for all tax supported funds (general fund, mass transit fund, recreation fund, etc.), in the event there is a need for those resources during the year from unanticipated revenue declines, expenditure increases, or newly identified expenditure needs. Maintaining a reserve for tax supported funds has been the practice of the Executive and Council for several years and has served the County well, as we have frequently experienced various, mid-year revenue declines from State aid reductions, income tax declines, and reductions in transfer and recordation taxes. In addition, we have used the reserves to fund snow removal/storm clean-up costs, facility maintenance and renovation costs, and other mid-year expenditure needs.

The County should not plan to spend all of the resources of the CFTD each year because: (1) this practice would not allow a reasonable operating margin for that year in the event of unanticipated fiscal challenges; and (2) reserves are a one-time source of funds and would need to be replenished with additional tax revenues the year after they are used (unlike the EMST fee, which is a recurring source of revenue). The amount of CFTD reserves (approximately $7.4 million in the beginning of FY09) would not be sufficient to fund the outstanding needs of MCFRS. The EMS Transport fee will generate annual revenues in excess of $14 million each year.

As is evident from the MCFRS needs enumerated in Question 1 in this Section, current tax supported resources are not sufficient for MCFRS even if the reserve was included, especially in this very constrained fiscal and economic environment. The increase in the MCFRS' FY09 budget was only 1.2% and included several operating reductions and program deferrals. This compared to an overall tax supported budget increase of 3.7%. This is why there is an urgent need for the type of dedicated funding source that the EMST fee would provide.

Question 3

For what purposes can funds in the Consolidated Fire Tax District be used? When funds are transferred out of the Consolidated Fire Tax District, how are they used?

Answer

Section 21-23(b) of the County Code provides that the CFTD revenues may be used for: (1) the management, operation, and maintenance of all fire and rescue services; (2) the purchase (including debt service), construction, maintenance, and operation of real and personal property necessary or incidental to fire and rescue services; (3) the operation of the Commission and MCFRS; (4) all tax-supported expenditures of the local fire and rescue departments; and (5) awards for the Length of Service Awards Program. The primary resource of the CFTD is the Fire Tax, but fees and fines, intergovernmental aid, and carryover of the previous years' reserves are other sources of CFTD revenues.

Question 4

Can all or part of the Consolidated Fire Tax District fund balance be transferred to the General Fund balance?

Answer

The County Council may approve a transfer under Section 309 of the County Charter. However, to the extent that the purpose of the transfer is inconsistent with the authorized uses of fire tax funds enumerated in Section 21-23(b) of the County Code, that section may need to be amended prior to the expenditure of the transferred funds.

Question 5

How would revenue from the EMST fee be used? Would it be available for use in the General Fund?

Answer

Bill 25-08 provides that EMST fee revenue "must be used to supplement, and must not supplant, existing expenditures for emergency medical services and other related fire and rescue services provided by the Fire and Rescue Service." As outlined in the Answer to Question 1 above, current priorities for use of EMST fee revenues include enhancing EMS staffing at new stations, implementing the Apparatus Management Plan, and supporting implementation of four-person staffing. EMST fee revenues would not be available for use in the General Fund.

Question 6

What would be done to assure that the revenue from the EMST fee will be designated solely for EMS service?

Answer

As outlined in the Answer to Question 5 in this section, Bill 25-08 makes it clear that EMST fee revenues must fund emergency medical services and other related fire and rescue services. Any appropriation of EMST fee revenues is subject to the review by MCFRS, the Office of Management and Budget, the Executive, and the Council. In addition, periodic reports on EMST fee revenues and uses will be provided to the Council

Question 7

What are the current MCFRS policies regarding transports from large medical facilities like Kaiser in Kensington? Does Kaiser currently charge patients for EMS service when MCFRS EMS units transport them?

Answer

MCFRS currently transports from private medical facilities like Kaiser on an emergent basis. MCFRS processes calls from these facilities in the same manner that it processes 911 calls. The Public Safety Communication Center (PSCC) uses emergency medical dispatch protocol established by the State (COMAR Title 30) to prioritize all requests for emergency medical services. MCFRS does not inquire or monitor Kaiser's policy on billing patients for its services.

Question 8

What will happen to an individual who cannot afford to pay an EMST fee or co-pay? Will their account be turned over to a collection agency? Will their failure to pay have a negative impact on their credit rating?

Answer

County residents are responsible for the EMST fee only to the extent of insurance coverage. An uninsured County resident will not be responsible for the EMST Fee. An uninsured resident may receive a written document requesting information about insurance coverage. An insured non-resident would be responsible for the cost of co-pays and deductibles, if any. An insured non-resident could apply for a hardship waiver of any applicable co-pay or deductible. An uninsured non-resident would be responsible for the EMST Fee. An uninsured non-resident could apply for a hardship waiver of the EMST fee.

Question 9

How will the EMST fee affect individuals who live outside the County but are visiting County residents or doing business in the County?

Answer

These individuals would be treated the same as other non-residents. See Answer to Question 8 in this section.

Question 10

As a policy matter, should the County exempt all uninsured residents from paying the EMST fee regardless of their ability to pay, or should there be a means test for an exemption?

Answer

Bill 25-08 provides that each County resident would be responsible for the EMST fee only to the extent of a resident's insurance coverage. The underlying reason for that component of the bill was to credit residents for the taxes they pay to the County; thereby more equitably distributing the economic burden of providing ambulance service in the County between residents and non-residents. We believe it is appropriate to distinguish between residents and non-residents in this manner.

Question 11

Should the County contract with a research organization to estimate the extent to which charging an EMST fee would discourage or delay individuals from calling for EMS service and the potential costs of any long-term health issues resulting from the delays?

Answer

Nearly all of our neighboring jurisdictions either have an EMST fee or are moving to implement one, including Fairfax County, Frederick County, Prince George's County, the District of Columbia, Arlington County, and the City of Alexandria. The 200 City Survey in the 2006 Journal of Emergency Medical Services (JEMS) reported that, across the country, an average of 61% of EMS system funding comes from user fees. There is no evidence from any of these jurisdictions that an EMST fee deters anyone from calling for needed emergency medical transport. We do not think it is necessary to conduct further research on this issue.

Question 12

Should the County provide for reciprocal fee arrangements with EMS services from neighboring jurisdictions?

Answer

We are not sure whether this is legally possible because EMST fees must be based on the cost of providing EMST services, which may vary among jurisdictions. However, we would be willing to explore this possibility if Bill 25-08 were enacted.

Question 13

If additional employees must be hired to administer the EMST fee, where would they be placed within the MCFRS organization?

Answer

The fiscal impact statement for Bill 25-08 projects a need for 6 new positions in the Division of Administrative Services. Those positions are discussed in more detail in the July 23, 2008 memorandum from OMB Director Joseph Beach to Council Staff Minna Davidson.

Question 14

The projected net revenues on page 5 of the Executive's overview packet show third party billing at 5%, but the dollar amounts are closer to 10%. Please explain what you assumed.

Answer

In FY09, the cost of third-party billing was assumed to be 5% of estimated gross revenues. In FY10-14, those costs were assumed to be 10%. That inconsistency was an oversight in the preparation of the chart. Based on the experience of Fairfax County with its third party billing vendor, a figure of 5.5% should have been used for each fiscal year.

Question 15

If an individual who received an EMS transport receives an insurer's explanation of benefits that indicates that the individual is responsible for a co-pay which the County does not collect, could the individual submit the charge for reimbursement under a healthcare flexible spending account?

Answer

Yes. The costs of emergency medical services are eligible for reimbursement under healthcare flexible spending accounts. However, as discussed in the Answer to Question 8 in this section, County residents would be responsible for the EMST fee only to the extent of

insurance coverage; therefore, they would not have any expenses that are eligible for reimbursement under a healthcare flexible spending account.

Question 16

Has the County approached Sibley Memorial and other out-of-County hospitals about cooperating in the provision of patient information for the County's EMST fee? If so, what was the outcome? If not, will these hospitals be contacted?

Answer

Representatives of MCFRS have met with representatives of five hospitals located in the County and each hospital is committed to cooperating in the provision of patient information to allow implementation of the EMST fee. Representatives of MCFRS have scheduled meetings with representatives of hospitals located outside the County to discuss this issue. MCFRS does not anticipate any difficulty in coordinating with those hospitals.

V. Email Message – September 10, 2008

Question 1

Do most medical insurance policies have lifetime maximums, and, if so, what are the typical dollar amounts for the maximums? Are insurance reimbursements for ambulance fees generally counted against lifetime maximums?

Answer

Managed care plans (health maintenance organizations and point-of-service plans) do not have lifetime maximum in-network benefits, and EMS transports are almost always in-network. Some indemnity plans have lifetime maximums, generally more than $1 million. An EMST fee would be counted towards that maximum.

VI. Email Message – September 17, 2008

Question 1

In Maryland all cars must carry PIP, the owner has the ability to waive PIP but then the passengers would still be covered as long as they were not resident relatives. So in the case of a car accident would the PIP carrier be billed? If there were not an assignment of benefits then the payment would go directly to the person who incurred the bill. Would the County then go after the individual to get the bill paid? PIP is a no fault coverage so it would not matter who is at fault or how many cars were involved in the loss there would not be a problem

with coverage. If a person is in a loss and someone calls the ambulance to the scene and the person does not take the ride to the hospital would there still be a charge?

Answer

EMS transport services are included in the Personal Injury Protection (PIP) coverage required by §19-505 of the Maryland Insurance Code. According to the County Attorney's Office, PIP coverage would be treated like any other insurance coverage for the purpose of implementing Bill 35-08. An EMST fee would not be imposed if there is no transport to a hospital.

KMB:jgs

Attachments (5)

cc: Joseph Beach, Director, Office of Management and Budget
Thomas Carr, Chief, Montgomery County Fire & Rescue Service
Marc Hansen, Deputy County Attorney

ATTACHMENT 1

CITY OF COLUMBUS
C/O MED3000
3131 NEWMARK DR, SUITE 100
MIAMISBURG, OH 45342

EMERGENCY SERVICES
REQUEST FOR INFORMATION

32491-98BS

RETURN SERVICE REQUESTED

0101

Account Number: [redacted]
Transport Date: 7/31/2008
Patient Name: [redacted]

[redacted]
COLUMBUS, OH 43205-3034

THIS IS NOT A BILL

32491-98BS*TFN0PQ071000001

On the above date you were transported by the City of Columbus to OH STATE UNIVERSITY MED CTR E. Please review the information listed below and make any necessary changes/corrections so that we may submit a claim for payment on your behalf. Please return this form to:

City of Columbus
C/O MED3000
3131 NEWMARK DR, SUITE 100
MIAMISBURG, OH 45342

Or call us at: 800-676-0111 between 8:30 A.M. and 4:00 P.M. or fax to 866-480-0594

Thank you for your prompt response to this request.

PRIMARY INSURANCE INFORMATION

Company: ANTHEM MEDICAID HMO
Address: PO BOX 37180
City/St/Zip: LOUISVILLE, KY 402337180
Policy Number: [redacted] Group: _____
Policy Holder's Name: [redacted]
Patient's SSN: _____

Patient's Date of Birth: [redacted]
Telephone: _____
Employer: _____
Relationship to Patient: _____
Insured's SSN: _____
Insured Date of Birth: [redacted]

SECONDARY INSURANCE INFORMATION

Company: _____
Address: _____
City/St/Zip: _____
Policy Number: _____ Group: _____
Policy Holder's Name: _____
Patient's SSN: _____

Telephone: _____
Employer: _____
Relationship to Patient: _____
Insured's SSN: _____
Insured Date of Birth: _____

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to "City of Columbus" for any services provided to me for now or in the future. I agree to immediately remit to "City of Columbus" any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to "City of Columbus". I authorize "City of Columbus" to appeal payment denials or other adverse decisions on my behalf without further authorization. A copy of this form is as valid as an original.

Patient Signature: _____ Date: _____

We are permitted to make uses and disclosures of protected health information for treatment, payment and health care operations. For a copy of our Notice of Privacy Practices, please call.

FAIRFAX COUNTY FIRE AND RESCUE DEPARTMENT

Request for Ambulance Fee Waiver

THIS FORM MUST BE SUBMITTED FOR EACH AMBULANCE TRANSPORT INCIDENT BILLED

APPLICANT NAME: _____

ADDRESS: _____

_____

TELEPHONE: _____(W)_____(H)_____(C)

**_MONTHLY_ HOUSEHOLD _GROSS_ INCOME FOR ALL ADULTS WHO WORK AND SHARE INCOME AND EXPENSES IN YOUR HOUSEHOLD: $_____

HOUSEHOLD SIZE (number of people):_____

***You must provide documentation to substantiate your monthly household gross income. Attach two current pay stubs or last year's tax return.* Other acceptable documents: financial aid approval from Inova or other hospital; social security statement; unemployment commission letter; homeless shelter letter.*

If you claim no income, attach a letter of explanation.

I am applying to Fairfax County Fire and Rescue Department to request a waiver of payment for my ambulance transport fee. I certify that I have no insurance that can be billed for this charge, that the above information is true and accurate to the best of my knowledge, and that I will be held responsible for any false statements made herein.

_____	_____	_____
Signature	**Printed Name**	**Date**

If you have any questions please call 703-246-2266. Please mail completed form and applicable documents to:

FAIRFAX COUNTY VIRGINIA
P.O. BOX 630232
BALTIMORE, MD 21263-0232

Appendix B
Comments from Mark Servello, Vice Chair, Volunteer Fire Commission

Background

In May 2004 the Fairfax County Volunteer Fire Commission, representing the twelve county volunteer fire companies, testified at the Board of Supervisors hearing regarding establishment of an EMS Transport billing structure. In that testimony, the Commission opposed the institution of EMS Transport billing for three reasons:

1) Motivation not to use the service

   The knowledge that a person will be charged, albeit through insurance, would create a different behavior and an inappropriate disincentive to use the EMS system. The provision of EMS is a basic responsibility of county government and charging for a service that is already funded through taxes is not appropriate.

2) Income timeline and use

   The income timeline is aggressive, and makes assumptions regarding the rate of insurance collection and the percentage of citizens covered by insurance that are optimistic. The income from this fee is returned to the county's general fund, and not used to directly supply/improve the service that generated it.

3) Optimistic implementation timeline

   The recent history of implementation of systemic changes in the Fire and Rescue service do not support the ability to meet the timeline for this change. Of particular concern is the handheld patient care computer required for all vehicles.

The Volunteer Fire Commission testified that while it opposes the EMS Transport billing, if the Board of Supervisors chose to implement such a fee the volunteer system would do its part in the combined system to make the implementation successful.

Volunteer Support to Implementation

A list of 15 volunteer personnel volunteered to participate as a part of the definition and implementation of the EMS Transport structure. Many of these personnel provided reviews of draft items or generated questions that were fed into the implementation team. Three personnel provided specific assistance as a part of the implementation project:

1) Ms. Terrie Callahan, Fair Oaks Volunteer Fire and Rescue Company

   Ms. Callahan, a federal contracting officer, provided technical assistance, review of draft documents, and advice in the preparation of Requests for Proposals for both the billing

services company and the EMS Handheld computer.

2) Mr. James Mathews, Franconia Volunteer Fire Department

   Mr. Mathews, an experienced journalist and mass communicator, worked with the Fire and Rescue Department's Public Information Office to prepare the communications strategy and reviewed sample brochures and releases.

3) Mr. Mark Servello, Fair Oaks Volunteer Fire and Rescue Company

   Mr. Servello is a project manager and technology consultant. He participated as a member of the implementation project team, and provided input and advice on the topics of project structure and tasking, billing process definition, and implementation training.

First Year Results

From the volunteer perspective, this was a successful implementation of a difficult activity. While we still do not believe that the EMS Transport fee should be charged to our citizens, we recognize that the fee system was implemented successfully with little impact on the delivery of service to the citizens and visitors of the county. The success of the implementation was, in our view, a result of a number of key factors:

1) The regular visible involvement and support from Fire Chief Michael Neuhard. Chief Neuhard established the implementation team, staffing it with senior officers and personnel from all appropriate parts of the Fire and Rescue Department including Fiscal Services, Quality Assurance, EMS Division, the Fire Chief's Office, and volunteers. This leadership from the top ensured that the implementation project maintained visibility and priority and received adequate resources from within the department and related county agencies.

2) The compassionate billing philosophy, established initially when defining the program during the Board's decision-making process, was especially important. This philosophy eased the transition of the fee into operation, providing assurance to both recipients and providers of EMS service that monetary concerns would not interfere with quality of care.

3) The decision by the implementation team to utilize the selected billing service vendor to acquire insurance information AFTER service delivery was crucial and fundamental, in hindsight, to the implementation. By not requiring the provider to request insurance information while also trying to render compassionate and effective EMS, and by not requiring the patient or family to provide such information in their time of need, the billing activity was taken completely out of the equation at the point of service delivery.

4) The decision to postpone selection and implementation of a handheld computer for EMS patient care reports, while difficult, was the correct choice. Delaying implementation of the billing activity beyond its publicly established deadline would have continued the

debate over the fee itself and generated additional resistance that would have been difficult to overcome. Selection of an inferior computer so that the deadline could be met would have resulted in resistance from the service providers and lack of value to the taxpayers for a system that did not truly meet the need.

Result of Volunteer System Concerns

Motivation not to use the service. Although call statistics are not readily available to the Volunteer Fire Commission from the *Altaris* system, through anecdotal and empirical information there has been no apparent drop in the number of calls for service or the number of transports to area hospitals that can be attributed to the existence of the EMS Transport fee. There is also no documented evidence supporting the contention that the existence of the fee would result in increases in insurance premiums, although we are not aware of a study of this factor.

Income timeline and use. The selected billing vendor has maintained a return rate well in line with projections for gross revenue to date. Changes in the FRD's Patient Care Report (PCR) coupled with training of personnel by the billing vendor to provide adequate information on the PCR have provided the necessary information to properly code and submit bills to the patient's insurance companies that are more likely to be accepted and paid within a reasonable turnaround time.

On a negative note, the training provided by the billing vendor was entirely appropriate if approached from the perspective of completing more accurate and detailed patient care reports for use in documenting patient care and reducing FRD liability for issues with patient care. Unfortunately, in classes attended by volunteers, the training was presented with an approach to improve the information so that the billing would result in a successful payment. While the material is the same, presenting it with an attitude of improving documentation of care that has an additional benefit to billing is much less likely to generate resistance to the fee or inappropriate behavior changes than presenting it with a goal of improving billing that has an additional benefit to improving documentation.

A factor that positively impacted the implementation was the decision to use the billing vendor to also maintain the data records of patient care necessary to meet reporting and recordkeeping requirements of the FRD. This was an unanticipated activity for the billing vendor that has resulted in a higher cost for that vendor than had been projected, reducing the net revenue to the system. While incurring a higher cost for processing PCRs due to the addition of record-keeping beyond processing bills and payments, this decision streamlined the service provider activity of after-event reporting and significantly improved the FRD activity of reporting data to the Virginia Office of Emergency Medical Services.

Aggressive implementation timeline. The EMS Transport implementation team met the timeline of implementing the billing activity on April 1, 2005. It did so, however, by implementing a manual process that negated or postponed work on systems that were originally intended to be ready to provide an automated process as a part of implementing the billing activity.

Prior to implementation of the billing process, the FRD had been working to replace an aging mainframe-based call record-keeping system with a PC-based system that would be easier to use, and would provide adequate record-keeping and data storage for reporting and analysis purposes. Work on the replacement system was stopped, and most of its record-keeping functions deactivated, when it became apparent that the new record-keeping system could not be modified to meet its original intent, coupled with billing, as a part of implementing the billing process on the deadline date. This was a driver in the decision to utilize the billing vendor to perform record-keeping and reporting functions for the FRD. While the result of this decision was a streamlined and easier-to-follow process for service providers to complete their post-care reporting, the time and funds expended on the new record-keeping system were effectively wasted.

The EMS Handheld computers, originally a cornerstone of the proposed automated billing process, are still not in place almost two years after the decision to implement the EMS Transport fee. Efforts have been underway from the start of the implementation project to specify, select, and install these computers in all EMS-related vehicles however they have not yet born fruit.

The result has been an implementation deadline that was met by a manual process and that, while effective, has resulted in a higher cost and delayed improvements in patient care reporting that had been intended to be integral parts of the implementation.

Volunteer System Impact

The impact to the volunteer system of implementing EMS Transport billing has been marginal, and has been focused in two areas: operational training and fundraising.

Operational Training. Following the provision of initial training for existing operational members there has been little impact on operational training. There is an additional training requirement for operational personnel regarding HIPAA requirements, procedures, and compliance. This training, however, has been integrated into the new member processing and is not causing an undue burden or negative impact on member applications.

Fundraising. There was concern during the decision-making process regarding the potential impact of EMS Transport billing on the ability of the volunteer companies to raise funds to support their operation. A survey of the volunteer companies conducted in April 2006 shows that fundraising results in the time since implementation have been mixed. Although some companies have received lower levels of contributions, others have received similar or higher levels of contributions. Even in those cases where contributions are lower than prior to April 2005, it is difficult to attribute the reason to the EMS Transport fee. The 2005 calendar year was an extremely heavy year of natural disasters around the world, and this may have been as big or a bigger impact on fundraising than the institution of the EMS Transport fee.

Summary

The implementation project team accomplished a tremendous amount of work to meet the implementation timeline established by the Board of Supervisors. The result is a billing process that, while manual at present, is functioning well and has had minimal impact on service delivery for either the provider or the patient. This is a credit to the implementation project team.

The primary concern remaining concern of the Volunteer Fire Commission is the selection and implementation of the EMS Handheld computer. This will require installation of a computer and related hardware in each EMS-related vehicle (and possibly equipment in each station), and it is unclear where the equipment will be mounted. In many vehicles, the space available is limited, having already consumed a significant amount with the Computer Aided Dispatch (CAD) Mobile Computer Terminals (MCTs).

The Volunteer Fire Commission recommends that adequate care be taken to ensure that another computer be added only if absolutely necessary. Where possible, functions should be combined to make best use of available technology and computers rather than adding another single-purpose computer to the vehicles.

The MCTs already installed in the vehicles are equipped for wireless communication over the existing radio system, a factor being considered for the EMS Handheld computers as well – but using cellular or "Wi-Fi" technology. It is unclear what advantage the cellular or Wi-Fi technologies will have over the existing wireless computer communication using the installed radio system for CAD functions.

The existing MCTs in most vehicles are aging machines, with most currently running the Windows 95 or Windows 98 operating system. Although many are being replaced with more current touch-screen MCTs, the underlying CAD application does not make full use of the computing power or capacity available in the newer computers.

Finally, there are additional technologies that are being considered for implementation in the FRD that should have a bearing on the technology direction for the EMS Handheld computers specifically and computers in vehicles in general. These include common technologies that have not yet been fully implemented in the FRD such as GPS navigation, Automatic Vehicle Locating, and suppression-related functions such as street map and preplan storage and alarm/inspection reporting. The Altaris CAD system itself is undergoing a re-specification as a part of the PSTOC.

All of these factors raise the concern that the single-purpose EMS Handheld, while improving the EMS functions of patient care and billing, may ultimately be an inefficient use of technology and resources in the vehicles and in the overall delivery of fire and rescue services.

Frederick County Volunteer fire and Rescue Association
President Michael Fyock
Ambulance Transport Insurance Billing Notes
July 8, 2008

Billing Began in 2002 or early 2003

Many fire and rescue companies had concerns that their annual fund drives and solicitations would suffer with implementation of ambulance transport billing.

Since implementation of ambulance transport billing there has been no measurable affect on volunteer companies' fund-raising or public approval.

Fire tax rates have been held down with ambulance transport billing funds being applied directly to personnel costs.

Volunteer fire and rescue companies are able to fund equipment, apparatus and buildings that would have not been realized without additional revenue received through ambulance transport billing.

Demographics and statistics are being obtained allowing for better planning.

The subscription club revenue serves as a co-pay for subscribers and a donation of sorts to the companies. There are no administrative fees deducted from these disbursements.

September 9, 2008

Mr. Wes Girling,
Benefits Manager
Montgomery County Government
Office of Human Resources
101 Monroe Street
Rockville, MD 20850

Dear Mr. Girling,

We cover licensed ambulance Services for Medicare and non Medicare members only if: (1) your condition requires either the basic life support, advanced life support, or critical care life support capabilities of an ambulance for inter-facility or home transfer; and (2) the ambulance transportation has been ordered by a Plan Provider. Coverage is also provided for medically necessary transportation or services rendered as the results of a 911 emergency. In most of these instances, no pre-approval is necessary.

In reference to your second inquiry regarding the payment of ambulance services for Medicare members, Medicare is the primary payor and Kaiser Permanente serves at the secondary payor.

Please let me know if you have any additional questions.

Sincerely,

Dana A. Smith
Senior Account Manager
Kaiser Permanente

Association Between Prepayment Systems and Emergency Medical Services Use Among Patients With Acute Chest Discomfort Syndrome

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Mr. Siepmann was a medical student at Oregon Health Sciences University (OHSU) during the time this research was conducted. The majority of Dr. Mann's efforts on this project occurred during his activity on the faculty at OHSU, Department of Emergency Medicine.

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Study objective: Cost concerns may inhibit emergency medical services (EMS) use. Novel tax-based and subscription prepayment programs indemnify patients against the cost of EMS treatment and transport. We determine whether the presence of (or enrollment in) prepayment plans increase EMS use among patients with acute chest discomfort, particularly those residing in low-income areas, those lacking private insurance, or both.

Methods: This study uses a subset of baseline data from the REACT trial, a multicenter, randomized controlled community trial designed, in part, to increase EMS use. The sample includes 860 consecutive noninstitutionalized patients (>30 years old) presenting with nontraumatic chest discomfort to hospital emergency departments in 4 Oregon/Washington communities. The association between prepayment systems and EMS use was analyzed using multivariable logistic regression.

Results: Overall EMS use was 52% (n=445). Among EMS users, 338 (75%) were subsequently admitted to the hospital and 110 (25%) were released from the ED. Prepayment was not associated with increased EMS use in the overall patient sample. However, patients residing in low-income census block groups (median annual income <$30,000) were 2.6 times (95% confidence interval [CI] 1.4 to 4.8) more likely to use EMS when a prepayment system was available than when no system was present. No association was noted among higher-income block group residents. Among low-income block group residents lacking private insurance, prepayment systems were associated with 3.8 times (95% CI 1.2 to 13.4) greater EMS usage.

Conclusion: Economic considerations may affect EMS system utilization among underinsured and low-income patients experiencing a cardiac event. Prepayment systems may increase EMS utilization among these groups.

[Seipmann DB, Mann NC, Hedges JR, Daya MR, for the Rapid Early Action for Coronary Treatment (REACT) Study. Association between prepayment systems and emergency medical services use among patients with acute chest discomfort syndrome. *Ann Emerg Med.* June 2000;35:573-578.]

INTRODUCTION

Potential benefits associated with the use of emergency medical services (EMS) among patients with symptoms of an acute myocardial infarction (AMI) include early diagnosis and treatment and the ability to manage life-threatening complications such as dysrhythmias.[1,2] Despite these benefits, studies have shown that fewer than half of patients admitted for possible AMI use the 911 service of an EMS system.[3]

Reasons given by chest pain patients for choosing to self-transport rather than call 911 include believing their symptoms were not severe enough, not thinking of calling 911, and considering self-transportation to be quicker.[4,5] Conversely, increasing age, the presence of other people during the cardiac event, medical history of angina, and increasing symptom severity have been associated with increased EMS usage.[4] The influence of cost concerns on the decision to activate (or not activate) the EMS system during a supposed cardiac event has not been well established because currently available studies evaluating the "intent to use EMS" were conducted in regions served entirely by tax-based, prepaid EMS systems.[3-7]

Previous research indicates that financial factors do influence care-seeking behaviors. For example, among those admitted to the hospital for any condition, the uninsured were 9 times more likely to delay seeking care because of cost concerns than those with insurance. Those both poor and uninsured were most likely to delay seeking care.[8]

Financial liability associated with EMS use varies considerably across communities in the United States. In areas with no prepayment systems, patients may be billed from $390 to $900 for a cardiac-related ambulance transport.[9] Locations with a tax-based prepayment system (publicly funded EMS) may not bill patients for their services. Also, hybrid EMS programs offer an optional "subscription" prepayment service in which members may be indemnified from the cost of EMS use by paying an annual membership fee.

This article examines the effect of tax-based and hybrid prepayment systems on EMS utilization among patients with chest pain in 4 cities in Oregon and Washington. It is hypothesized that prepayment systems will be associated with greater EMS use, especially among low-income patients and those without private insurance.

MATERIALS AND METHODS

This study uses baseline data collected from October 22, 1995, to March 31, 1996, as part of the Rapid Early Action for Coronary Treatment (REACT) trial. REACT is a randomized, controlled, matched-pair community trial designed to test an intervention intended to reduce patient delay between the time of cardiac symptom onset to arrival at the hospital. The design and rationale for the REACT trial have been described in detail previously.[10,11] Retrospective data abstracted from all area hospitals in one matched-pair set of communities from each state (Oregon and Washington) were included to assess the effect of prepayment systems on EMS utilization controlling for factors known to affect EMS use. This study was considered exempt from patient consent requirements by the Oregon Health Sciences University Institutional Review Board.

Data were collected from EDs in 2 community hospitals in 2 Oregon cities and 4 community hospital EDs in 2 Washington cities. Participating hospitals capture 90% of patients with acute coronary heart disease seeking emergency care in each community. The 4 cities were pair-matched within each state by size and demographics (Table 1). In one Oregon community, EMS are provided by a private company and the patient's insurance company is billed for the service. Patients are directly responsible for charges not covered by health insurance. The second Oregon community offers an optional prepayment scheme (nominal fee of $35/year) that indemnifies the patient for any charges not covered by health insurance. In the Oregon community with an EMS prepayment system, 57% of study subjects subscribed to the prepayment system. The 2 Washington communities have tax-based EMS systems and do not bill patients for their services. Enhanced 911 coverage in each study community was absolute.

ED logs in each study hospital were monitored for patients presenting with chest pain, pressure, or tightness with or without discomfort. Patients were included in the sample if (1) there was no obvious trauma etiology explaining the complaint of chest discomfort, (2) the patient was older than 30 years and resided within ZIP code boundaries defining REACT communities, and (3) the patient was not institutionalized or transferred from another hospital.

Variables abstracted from ED records included mode of transport (ambulance versus other) and several demographic variables previously associated with the decision to use EMS (ie, age <65 versus ≥65 years, subsequent hospital admission, gender, employment status, and living with a significant other).[4,5] The prepayment subscription status of each patient in the second Oregon community was obtained from local EMS billing records. Tax-based and subscription services were combined to create a binary variable (prepayment [yes, no]).

Because no measure of socioeconomic status was available in REACT baseline data, a process of address matching was used to classify each patient as a resident of either a high-income (median annual household income ≥$30,000) or a low-income (median annual household income <$30,000) census block group based on US census data.[12] Census block groups are the smallest geographic units for which detailed demographics are available from the US Census Bureau. Block groups in this study included from 250 to 476 housing units per group and demonstrated median annual household incomes ranging from $6,145 to $88,081.

Standard bivariate statistics were used to examine patient demographics. Multivariate logistic modeling was used to assess the influence of prepayment systems on EMS usage, controlling for covariates previously associated with EMS use (ie, age dichotomized as <65 and ≥65 years, gender, whether admitted, whether employed, and existence of a significant other).[3-5] Multivariate analyses were performed on all residents, residents of high- and low-income census block groups, and those with and without private insurance. All of the covariates were entered into the logistic models in a single step (ie, a "forced entry" technique). The dichotomous measure identifying the presence of a prepayment system was then entered in a second step.[13] The appropriateness of resulting models was assessed using a Hosmer-Lemeshow goodness-of-fit statistic.[14] All database management and statistical analyses were conducted using SPSS for Windows version 9.01 (SPSS Inc, Chicago, IL).

RESULTS

Of 1,086 patients presenting to participating EDs with chest discomfort, data regarding the mode of transport to the ED were available for 929 (85%). There were no meaningful differences with respect to demographic variables between patients with and without transport data. Ninety-three percent (860) of patients with transport data were successfully matched to a census block group. The remaining patients could not be matched because of missing or incomplete address data, or because addresses were in new construction areas. Unmatched patients did not differ in age, gender, admission status, employment status, level of EMS usage, or in the presence or absence of a payment system from those with matched addresses. Patients without mode of transport data or valid addresses were excluded from further analysis. The final study sample consisted of 860 patients, of whom 448 (52%) used the EMS system. Among those using EMS, 75% were subsequently admitted to the hospital compared with 25% who were released from the ED (Table 2).

The study sample was generally well insured (Table 3); 71.1% of patients had private insurance and only 5.9% of patients were completely uninsured. Residents of low-income census block groups were less likely to possess private insurance ($\chi^2[1]=7.05$, $P=.007$) compared with residents of high-income census block groups.

The logistic models reported below demonstrate a moderate to good fit of the data ($P=.338$ to $P=.832$), cor-

Table 1.
Demographic characteristics of the 4 Northwest REACT communities.

Site	Population	Area (sq mi)	Income ($, median household)	Age (%)		Race/Ethnicity				
				30–54 y	55+ y	White	Black	Hispanic	Asian	Other
Oregon A	87,594	35.5	$36,253	39.6	13.2	90.0	0.9	3.5	7.2	2.0
Oregon B	112,669	39.1	$25,369	31.4	19.2	93.4	1.3	2.7	3.5	1.8
Washington A	126,647	33.7	$36,258	37.9	24.1	86.0	2.2	2.7	9.8	1.9
Washington B	69,156	35.8	$28,686	35.2	22.5	90.5	2.1	3.1	5.2	2.2
Mean for US 1990 census			$29,943	33.9	20.9	81.3	12.5	10.0	3.5	1.8

A and B indicate blinded communities.

rectly classifying between 64% and 72% of all patients. All models included as covariates age, gender, admission status, employment status, and presence of a significant other in the household.

Findings based on the overall patient sample suggest that individuals older than 65 years and those who were subsequently admitted to the hospital are significantly more likely to activate the EMS system compared with younger patients and those released from the ED (Table 4). Prepayment systems for EMS were not found to significantly affect EMS usage in the overall patient sample. Other covariate factors not significantly associated with EMS use included employment status, gender, or presence of a significant other.

When the patient sample was subdivided by residence in either a high (≥$30,000) or low (<$30,000) annual income census block group (Table 5), both models continued to demonstrate that older age and hospital admission are significant predictors of EMS usage. The analysis also indicated that among patients residing in low-income census block groups, the presence of a prepayment system was associated with 2.6 times greater EMS use (95% confidence interval [CI] 1.41 to 4.79) compared with similar patients with no regional system (or

Table 2.
Sample characteristics and EMS use (by hospital admission and release from the ED) for study communities.

Sample Characteristic	Oregon A	Oregon B	Washington A	Washington B
Patient age (y, mean±SD)	62±16	66±15	65±16	63±15
Sex (% female)	56 (51.9)	91 (48.1)	116 (56.0)	173 (48.6)
Has partner (% yes)*	68 (63.0)	112 (59.3)	115 (55.6)	215 (60.4)
Employed (% yes)	43 (39.8)	47 (24.9)	64 (30.9)	118 (33.1)
Median annual household income ($)	34,908	28,725	35,313	31,387
EMS use (% yes)	62 (57.4)	75 (39.7)	117 (56.5)	194 (54.5)
Hospital admission (% yes)†	55 (88.7)	58 (77.3)	87 (74.4)	138 (71.1)
ED release (% yes)	7 (11.3)	17 (22.7)	30 (25.6)	56 (28.9)
EMS use (% no)	46 (42.6)	114 (60.3)	90 (43.5)	162 (45.5)
Hospital admission (% yes)	17 (37.0)	65 (57.0)	37 (41.1)	89 (54.9)
ED release (% yes)	29 (63.0)	49 (43.0)	53 (58.9)	73 (45.1)
Total no. of patients	108	189	207	356

A and B indicate blinded communities.
*Percentages based on the entire sample in each community.
†Percentages in subcategories based on the sample in the parent category.

Table 3.
Insurance coverage by census block median annual household income.

Insurance Coverage	Low-Income (<$30,000) No. (%)	High-Income (≥$30,000) No. (%)
Private non–health maintenance organization	144 (40.8)	270 (53.3)
Private health maintenance organization	92 (26.1)	111 (22.2)
Medicare without supplement	65 (18.4)	61 (11.9)
Uninsured	27 (7.6)	24 (4.7)
Medicaid/state insurance	15 (4.2)	24 (4.7)
Military insurance	6 (1.7)	8 (1.5)
Unknown	4 (1.2)	9 (1.7)
Total no. of patients	**353**	**507**

Table 4.
Logistic regression modeling for factors associated with EMS use (all patients).

Variables	b*	Adjusted OR	95% CI
Age (≥65 y)	0.767	2.15	1.45–3.19
Admitted (yes)	0.964	2.62	1.88–3.65
Sex (male)	0.203	1.22	0.88–1.70
Employed (yes)	−0.262	0.76	0.50–1.16
Has partner (yes)	0.086	1.09	0.77–1.53
Prepayment system (yes)	0.403	1.49†	0.98–2.18

*Estimated variable coefficients.
†Odds ratio adjusted for covariate factors by including the prepayment variable in a second step.

those failing to subscribe to a prepayment plan). A similar effect was not found among patients residing in high-income census block groups.

Among residents of low-income census block groups without private insurance (n=113), the presence of a prepayment program was associated with 3.87 times (95% CI 1.22 to 13.36) greater EMS use compared with similar patients with no such system available. Among those residing in low-income census block groups with private insurance (n=236), prepayment programs were also associated with greater EMS usage (adjusted odds ratio [OR] 2.38, 95% CI 1.15 to 4.94) when compared with similar patients without prepayment coverage. The only covariate measure remaining a consistent and significant predictor of EMS use in these analyses was admission status.

The presence of a prepayment subscription service in one Oregon study community makes it possible to compare EMS usage among residents with subscriptions (and those without) in the same community. Prepayment subscribers residing in low-income census block groups were 2.89 times more likely (95% CI 1.20 to 6.94) to activate the EMS system than low-income nonsubscribers. None of the other included covariates were significantly associated with EMS use (n=115).

Among residents of low-income block groups in all 4 communities who were subsequently admitted to the hospital (n=116), the presence of a prepayment mechanism significantly increased EMS use (adjusted OR 2.75, 95% CI 1.30 to 5.83) compared with those with no such mechanism. Prepayment was not significantly associated with increased EMS use, comparing patients with and without a prepayment mechanism, who were released from the ED (adjusted OR 2.11, 95% CI 0.73 to 6.04 [n=123]). No other covariates proved significant in either of these analyses.

DISCUSSION

Findings indicate that tax-based and hybrid EMS prepayment plans were not associated with EMS use among the overall sample of patients with acute chest discomfort. However, patients with chest pain who reside in lower-income census areas were 2.6 times more likely to use EMS if a prepayment system was available. Similarly, prepayment mechanisms increased EMS usage fourfold among residents of low-income census block groups without private insurance. These findings suggest that economic factors may affect the decision to use the EMS system among lower-income and underinsured patients with acute chest discomfort.

Additional research will be required to determine whether financial considerations affect EMS utilization under varying circumstances (eg, acute versus chronic conditions). In addition, future research may investigate the cost-effectiveness of prepayment plans in differing health care environments using a broader case definition.

There are several limitations in study design that qualify the findings of this study. The use of census block groups to assign individual patient household income infers an ecologic bias. In addition, household income may be a poor proxy for ability to pay for ambulance services. There are potentially confounding unmeasured community factors that may influence the decision to use EMS, such as differences in community structure (number of hospitals, population density) and differences in the medical care systems (penetration of managed care,

Table 5.
Logistic regression model of factors associated with EMS use (by high- and low-income census block groups).

	Low-Income Group			High-Income Group		
Variables	**b***	**Adjusted OR**	**95% CI**	**b***	**Adjusted OR**	**95% CI**
Age (≥65 y)	0.665	1.94	1.05–3.58	0.860	2.36	1.38–4.02
Admitted (yes)	1.090	2.97	1.75–5.04	0.886	2.42	1.57–3.74
Sex (male)	0.475	1.60	0.94–2.72	−0.012	0.98	0.64–1.51
Employed (yes)	−0.529	0.58	0.30–1.14	−0.093	0.91	0.52–1.58
Has partner (yes)	0.329	1.39	0.81–2.37	−0.086	0.91	0.57–1.45
Prepayment system (yes)	0.956	2.60†	1.41–4.79	0.005	1.00†	0.61–1.63

*Estimated variable coefficients.
†Odds ratio adjusted for covariate factors by including the prepayment variable in a second step.

public confidence in the EMS system, and so on). The community-matching process used in the REACT trial attempted to minimize some of these potential sources of bias. It is also possible that EMS that offer indemnity programs or are tax-based may promote EMS more aggressively than traditional fee-for-service programs. Notwithstanding this concern, an unpublished survey conducted in one of the Washington study communities indicated that only one third of resident seniors were aware that EMS usage was free of cost.

Finally, because this study is based on a chart review and not on patient surveys, we did not directly address issues of patient motivation in decisionmaking regarding EMS use. Previous survey research has shown that cardiac symptom severity, recognition of symptoms, and medical history of angina are all associated with increased EMS use.[4] Future studies should incorporate case-specific financial measures to better assess the interplay between physiologic factors, environmental factors, and economic concerns in patient decisions surrounding EMS use.

The analysis based solely on patients in the second Oregon community provided a comparison of EMS use among those who did and did not participate in an EMS subscription prepayment service within the same community environment, thus mediating the confounding effect of unmeasured community factors. However, the interpretation of this data is limited by the self-selection of prepayment subscribers. It may be that those who chose to subscribe are more health conscious and therefore more likely to use EMS regardless of the influence of the prepayment system.

Finally, results associated with insurance status are less than straightforward. Because most study patients "without private insurance" were insured by federal or state sources, it is unclear why the presence of a prepayment system produced such a profound effect on EMS use among this population. Perhaps lower-income Medicare recipients are more likely to have experienced marginal costs from prior EMS use.

Prior research asserts that Medicaid recipients who lack financial liability for EMS use are more likely to request an ambulance transport that was considered "medically unnecessary."[15] Concern may be expressed that prepayment systems could augment overuse of EMS by low-income populations. Although it is questionable to equate admission status with "appropriateness" of EMS transport, our findings do indicate that among residents of low-income areas, prepayment was associated with significantly increased EMS use only in those subsequently admitted to the hospital.

In summary, despite potential limitations, this study documents that prepayment systems for EMS use, including publicly funded tax-based systems and optional subscription systems, may serve to increase the appropriate use of EMS among underinsured and low-income patients experiencing acute chest discomfort.

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Clinical Investigation and Reports

Demographic, Belief, and Situational Factors Influencing the Decision to Utilize Emergency Medical Services Among Chest Pain Patients

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Background—Empirical evidence suggests that people value emergency medical services (EMS) but that they may not use the service when experiencing chest pain. This study evaluates this phenomenon and the factors associated with the failure to use EMS during a potential cardiac event.

Methods and Results—Baseline data were gathered from a randomized, controlled community trial (REACT) that was conducted in 20 US communities. A random-digit-dial survey documented bystander intentions to use EMS for cardiac symptoms in each community. An emergency department surveillance system documented the mode of transport among chest pain patients in each community and collected ancillary data, including situational factors surrounding the chest pain event. Logistic regression identified factors associated with failure to use EMS. A total of 962 community members responded to the phone survey, and data were collected on 875 chest pain emergency department arrivals. The mean proportion of community members intending to use EMS during a witnessed cardiac event was 89%; the mean proportion of patients observed using the service was 23%, with significant geographic differences (range, 10% to 48% use). After controlling for covariates, non-EMS users were more likely to try antacids/aspirin and call a doctor and were less likely to subscribe to (or participate in) an EMS prepayment plan.

Conclusions—The results of this study indicate that indecision, self-treatment, physician contact, and financial concerns may undermine a chest pain patient's intention to use EMS.

Key Words: coronary disease • epidemiology • public policy

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Every year, ≈1 250 000 persons in the United States experience an acute myocardial infarction (AMI).[1] Of these, >50% die before reaching a medical facility. A majority of these deaths occur within 1 hour of the onset of acute symptoms.[1,2] Thrombolytic therapy and other coronary reperfusion strategies are critical in altering the course of an AMI; they can reduce mortality by 25% if initiated within 1 hour of the onset of acute symptoms.[3] Unfortunately, only a fraction of patients who are eligible for thrombolytic therapy receive treatment; this is due, in large part, to the time delay between the onset of acute symptoms and arrival at the hospital.[4,5,6,7,8,9,10]

Little is known about a patient's decision to use the emergency medical service (EMS) system during a chest pain event. EMS system use can be crucial to receiving prompt therapy for a possible AMI. Benefits include early diagnosis and treatment, emergency department (ED) forewarning of patient arrival, and the ability to address life-threatening complications, such as dysrhythmias, during

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transport.[11] [12] However, studies indicate that only 50% to 60% of patients with chest pain use the EMS system.[13] [14]

Factors associated with EMS use among chest pain patients presenting to EDs were previously investigated in 2 concurrent studies in King County, Washington.[9] [15] The first study focused on the association between EMS use and demographic, situational, and clinical factors; the authors of this study reported that greater education and being physically active at the time of symptom onset were related to decreased EMS system use.[9] The second study evaluated knowledge and belief issues surrounding EMS use and found that chest pain patients fail to use EMS because they do not perceive their symptoms as being life-threatening, they did not think of calling 911, or they thought self-transport would be faster.[15] An important limitation in the current literature is that all published studies evaluating EMS use among chest pain patients originate from one state with a tax-based, prepaid EMS system.[9] [13] [15] [16] [17] [18] Thus, geographic differences and the impact of cost concerns on EMS use remain uninvestigated.

The objective of the current study was to determine if community members recognize the benefit of the EMS system in a cardiac emergency and to compare these findings to actual EMS usage. This study documented geographic variations in bystander intention to use EMS services among 20 diverse communities in the United States and compared these findings to actual EMS utilization rates among chest pain patients in each community. In addition, survey data provided by chest pain patients presenting to participating EDs were used to determine how demographic factors, situational attributes, and patient perceptions influence the decision to access the EMS system.

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Study Design

The data for this study were drawn from a subgroup of all patients included in the REACT trial.[19] REACT was a multicenter, randomized, controlled community trial designed to evaluate the effects of a community intervention on the time interval between onset of AMI symptoms to contact with hospital-based emergency medical care.[19] [20] In brief, 20 communities were pair-matched by demographic characteristics in 5 regions throughout the United States. One community of each pair was randomly assigned as the intervention site and the other served as a control site. Four months of baseline data were collected in all communities; this was followed by an 18-month, multifaceted education program in the intervention communities. Data used in this study were collected from all 20 communities during the baseline period (December 1995 through March 1996) before the intervention was initiated. In the REACT trial, patient consent requirements were reviewed and approved by all participating hospitals.

Sample Characteristics

For this study, data were provided by 2 sample sources: a random-digit-dial (RDD) community telephone survey and a telephone follow-up survey of chest pain patients presenting to participating EDs and either released or admitted to the hospital with a possible or confirmed coronary event. A

review of the medical records for patients participating in the telephone follow-up survey was also conducted.

The RDD community survey was administered among ≈60 adults who were ≥18 years of age in each of the 20 communities. Telephone exchanges and a count of households with listed phone numbers were obtained for specific zip code areas designating the geographic boundaries of each community. Counts of listed households were supplemented with estimates of unlisted households. Disproportionate stratified sampling was used to increase the overall household rate. To adjust for the complex sample design, survey responses were weighted by the reciprocal of the probability of selection. For purposes of this study, only community respondents ≥30 years of age were included in the analysis to facilitate comparison with the follow-up survey.

The telephone follow-up survey included both an ED telephone survey and a hospital inpatient telephone survey. The ED follow-up telephone survey was conducted 7 to 13 weeks after the ED visit for patients presenting to EDs with chest pain but who were subsequently released without a hospital admission. The inpatient follow-up telephone survey, which was conducted 7 to 13 weeks after hospital discharge, was administered to admitted patients with a confirmed *International Classification of Diseases*[21] discharge code of AMI (410) or acute cardiac ischemia (411). Disproportionate stratified random sampling was applied with sampling fractions adjusted for community size and patient response for both the ED survey and inpatient survey. Because patient sampling and survey response rates differed by community, responses were weighted by the number of eligible persons (released from the ED or admitted to the hospital) divided by the number of completed interviews.

The 2 follow-up telephone surveys were appended and merged with hospital medical chart data. This combined database, referred to as the patient follow-up survey, was limited to patients who were ≥30 years of age who presented to the hospital with non-traumatic chest pain.[19] Patients were excluded if they were institutionalized or transferred from another hospital.

Additionally, each EMS and fire service agency in each REACT community was queried regarding the availability of a prepayment system. EMS prepayment systems indemnify citizens against the cost of EMS treatment and transport.[13] Systems may be tax-based (publicly funded EMS) programs, which do not bill patients for services, or hybrid EMS programs that offer an optional prepayment service that, on the basis of an annual membership fee, indemnifies the patient against any charges not covered by health insurance.

Measurements

Data contained in the RDD community telephone survey were used to identify community perceptions regarding the value of EMS services during a cardiac event. Specifically, the following question addressed bystander intentions during a coronary emergency: "If you thought someone was having a heart attack, what would you do?" Two optional responses, among many, were the following: (1) call 911 or an ambulance and (2) drive the person to the hospital. By comparing the community telephone survey findings with the EMS utilization data contained in the patient follow-

(60)

up survey, we could compare community perceptions regarding intended bystander EMS usage with actions taken by community members experiencing a suspected coronary event.

The patient follow-up survey also contained questions assessing demographic, situational, and belief factors associated with the chest pain event that led patients to seek medical attention. Thus, we could also associate EMS use with patient demographics, patient appraisals of their medical condition, actions taken before seeking medical attention, and various beliefs and perceptions that facilitated or hindered quick action when seeking medical care.

Data Analysis

Descriptive statistics were used to assess the similarity among the independent samples used in this study. In addition, an exploratory analysis was conducted with patient follow-up survey data to identify demographic, belief, and situational factors associated with the decision to activate (or not activate) the EMS system. Demographic factors and other variables associated with EMS activation in the exploratory analysis were included in a mixed-effects logistic regression model predicting the primary mode of transport (EMS versus other). Design effects associated with the REACT trial were incorporated into the model, in which "study pair" was nested within "geographic region," and "community" was nested within "pair" and "region" using the glimmix macro for the SAS system.[22] Contributions to the model are reported as adjusted odds ratios. All analyses were conducted using SAS, version 6.12.

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Survey Response Rates

In the RDD community telephone survey, 36.9% of the randomly generated telephone numbers were for zip code–eligible households (n=2067). In addition, 55 calls to households resulted in no contact after 15 attempts. Among those contacted, 520 resulted in refusals, 62 were ineligible due to a language barrier (non-Spanish or English) or illness, and 136 provided incomplete interviews. The overall interview rate (completed interviews divided by potentially eligible households) was 62.5%. The total sample (≥30 years of age) included 962 respondents.

Response rates for the ED telephone survey and hospital inpatient telephone survey that were appended into the patient follow-up survey are reported separately. For the ED telephone survey, 426 people provided complete interviews out of the 1338 we attempted to contact. Because of a slow study start-up, 18.1% (n=243) of cases were excluded because the 13-week interview window had expired before consent could be obtained. An additional 300 people could not be contacted (eg, non-working phone number). Among those contacted (n=795), 46.4% of people refused the interview or were found to be ineligible during the interview process (ie, too ill, died, deaf, or currently in a nursing home). The overall response rate (number interviewed/[number selected-number ineligible]) was 34.4%.

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For the inpatient survey, 449 of 1787 patients provided complete interviews. Among contacted patients (n=1521), 23.3% refused the interview and 47.1% of respondents were found to be ineligible during the interview. The overall response rate was 42.0%. The final sample sizes for the surveys were 962 and 875 for the RDD community survey and the patient follow-up survey, respectively.

Sample Characteristics

Table 1 lists demographic variables for each of the survey samples. The inpatient survey respondents were older and more frequently reported their ethnicity as non-Hispanic white. A greater proportion of ED survey respondents were male. Participants in the RDD community survey reported higher levels of education.

View this table: **Table 1.** Summary of Sample Characteristics for the 3 Telephone Surveys
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Intention to Use EMS and Actual EMS Use

Table 2 uses data from the RDD community telephone survey and the patient follow-up survey to compare bystander intent to use EMS with self-reported EMS use in each study community. On average, 89.4% of respondents in each study community indicated that they would call 911 if they witnessed a cardiac event. Very few (8.1%) would consider driving someone with a coronary emergency to the hospital.

View this table: **Table 2.** Comparison of Bystander Intention to Use EMS and Self-Reported EMS Utilization Rates
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The patient follow-up survey provided EMS use information for chest pain patients presenting to participating EDs in each study community. Contrary to the bystander intentions expressed in the community survey, few actual chest pain victims used EMS (23.2%). Most victims were driven to the ED by someone else (60.4%) or drove themselves to the hospital (15.6%).

Factors Associated With Actual EMS Use

Demographic Variables

Using the patient follow-up survey data, demographic, situational, and belief factors were compared among EMS and non-EMS users. Several demographic variables were significantly associated with EMS use, including increasing age, white ethnicity, living alone, and presence of an ambulance service prepayment plan (Table 3).

View this table: **Table 3.** Demographic, Situational, and Belief Factors Associated With Use of EMS Services
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Situational Factors

When considering actions taken by patients before calling 911 or going to the hospital, patients taking an antacid or aspirin were less likely to use EMS services. However, patients taking nitroglycerin were twice as likely to choose EMS transport. Regarding communications with others, requesting advice from family or friends before seeking medical attention was not associated with EMS use. However, patients communicating with a physician were less likely to use EMS transport to the hospital.

Belief Factors

The following question was significantly associated with EMS use (Table 3⊞): "Did any factors or things cause you to go quickly (or wait to go) to the hospital?" Post hoc analyses of answer subcategories indicated that certainty that a patient's symptoms were caused by a "heart attack" was associated with an increased likelihood of choosing EMS transport, whereas patients who thought their symptoms would go away were significantly less likely to use EMS. Pain severity was not associated with EMS use.

Multivariate Analysis

Using a multivariable logistic regression model, we examined the associations of the following factors with EMS use: sex, ethnicity (white versus non-white), living alone, taking nitroglycerin, communicating with a physician, and being prompted to "go quickly" or "waiting" to go to the hospital. The variable identifying the presence of an EMS prepayment system was trichotomized to independently assess the effect of subscription services verses tax-based programs. The variables "took antacid" and "took aspirin" were combined to address the issue of a patient's self-medicating during a potential cardiac event. Age was excluded from the model because of its strong association with 2 other variables, "living alone" and "taking nitroglycerin." Separate models were analyzed using weighted and unweighted survey responses. Regression coefficients between the models were similar; thus, we report only the unweighted results.

The overall fit of the logistic model was good; it correctly classified 76% of all cases (Table 4⊞). The variables "living alone," "taking nitroglycerin," and being prompted to "go quickly" to the hospital were strong predictors of EMS use. The presence of a tax-based, prepaid EMS system doubled the likelihood of using EMS compared with communities with no such system. Because the presence of an EMS prepayment plan was measured on the community level rather than on an individual level, including random effects associated with community appropriately inflated the confidence band associated with this variable. Thus, the 95% confidence interval associated with the prepayment variable included unity, so that statistical significance could not be attributed to a prepayment effect. This variable should be interpreted with some care. Being prompted to "wait before going," taking an antacid/aspirin, or consulting with a physician significantly decreased the likelihood that respondents would use EMS services.

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Table 4. Multivariate Logistic Analysis of Demographic, Situational, and Belief Factors That Affect EMS Use

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Findings indicate that, in general, community members recognize the benefit of EMS transport when acting as a bystander to a "public" cardiac event but individuals personally experiencing symptoms of an AMI often choose not to use EMS services. One should note, however, that bystander intentions may favor an EMS response simply because respondants assumed they were unacquainted with the victim and his/her extenuating circumstances. Bystander decisions can be decisive if personal circumstances do not complicate bystander decision-making. Alternatively, actual patients may not have considered their symptoms to be indicative of a heart attack and were, therefore, less inclined use EMS. It is unclear if similar findings would be present if intentions and actual events were documented for the same subject. Nevertheless, the magnitude of difference between bystander intentions and actions for self and the uniformity of this finding across geographic regions suggest that further investigation may prove useful in determining why the public would choose alternative transportation when faced with a cardiac emergency.

Situational factors that decreased EMS use during a cardiac event included taking an antacid/aspirin or communicating with a doctor before going to the hospital. However, patients taking nitroglycerin and patients believing their condition was heart-related were more likely to use EMS. These findings suggest that patients with familiar symptoms or experience with a heart condition are more likely to rely on EMS care as a valued form of medical care and transport. Additional published work has associated symptom familiarity with increased EMS use.[15]

The fact that communication with a doctor decreased EMS use is problematic. It is unclear if doctors were acting as managed care "gatekeepers" to EMS care or if they reduced patient anxiety in a way that made EMS transport seem optional. There may be a variety of valid reasons why physicians who are familiar with individual patient histories may not dictate EMS use during phone contact with a concerned patient. However, our data indicate that 83% of patients who spoke with a physician and did not use EMS transport were subsequently admitted to the hospital.

Regarding belief factors, no correlation existed between seeking advice from peers or pain severity and EMS transport, which is contrary to other studies demonstrating a positive correlation between these factors and EMS use.[6 9 15] The perception among patients that their symptoms would go away decreased EMS use; this result is similar to findings reported elsewhere.[15]

Several demographic variables were associated with EMS use. Living alone and increasing age

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(although unadjusted) enhanced EMS use. These results may reflect the fact that the elderly and those in single-person households have fewer transportation options. Other demographic variables, including ethnicity, sex, and education, were not related to EMS use, which contrasts with the results of previous studies.[6 8 9] However, one should note that previous research addressing this question originated in one state with a relatively high EMS use rate.[9 13 15 16 17 18] Thus, contradictions between previous findings and current results may represent geographic differences in patient population, EMS structure, etc.

Of interest is the fact that the presence of an EMS prepayment system increased EMS use. One other study documented a similar increase among residents of lower income census blocks.[13]

There are several important limitations to this study. A potential source of bias relates to the fact that ED and inpatient survey data were obtained retrospectively, 7 to 13 weeks after the cardiac event. The event or the extended period of time between the event and our interviews may have affected patient responses. At least one other study, however, has shown that acute health conditions requiring medical attention often represent "sentinel events" and may be accurately recalled for up to 6 months.[23] A second limitation involved the low response rate to the ED and inpatient surveys (<42%). Missing interviews may systematically favor an income group, degree of chronic illness, or some other unmeasured variable that limits the generalizability of our findings. The fact that our study sample included communities with diverse mean incomes and ethnic distributions may temper some potential bias due to sample selection.[19]

In summary, people seem to understand the prudent actions to take when faced with a public cardiac event, but they may be unwilling to take the appropriate steps when facing a personal cardiac emergency, perhaps due to symptom uncertainty or other behavioral factors. Variables representing demographic, situational, and self-efficacy (or belief) factors can inhibit or promote EMS use during a cardiac event. Subscription services and taxed-based systems that offset the cost of EMS services need to be analyzed further to determine if these programs represent a major factor among patients evaluating options for emergency transportation.

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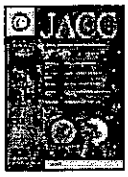

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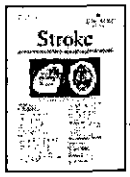

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- Articles by Brown, A. L.
- Articles by Cooper, L.

Related Collections

- Health policy and outcome research
- Acute coronary syndromes
- Epidemiology

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4 Falls Chapel Court
Potomac, MD 20854
July 8, 2008

Michael J. Knapp
Council President
Montgomery County Council
Stella B. Werner Office Building
Rockville, MD 20850

In re: Emergency Medical Transport Fee

Dear Council President Knapp:

Previously during the budget process hearings I had spoken against the imposition of the ambulance fee covering three points. First, it is my belief that the evacuation of sick and injured residents to emergency medical facilities is an essential government function that should be paid for under existing tax regimes. Second, existing tax gathering programs are very efficient for example the Comptrollers' office can collect a dollar's worth of State/County income tax for less than 1/3 of a cent. Third, increasing the costs of the usual payers of medical services such as insurance companies will ultimately lead to increased premium costs to County residents. (Part of such cost increases when premiums increase is the premium taxes that Maryland companies (to include health maintenance organizations) pay.)

The essence of insurance is risk shifting and risk distribution. When a baby comes into a family by law and custom the provision of paying for the child's medical services is shifted to his or her parents. Risk distribution is a math concept. Entities that assume risks are typically an insurance company or a large employer in a self-insured medical plan. Such entities take advantage of the statistical phenomenon known as the law of large numbers. Thus, there is an increase in predictability of the average loss that will be incurred by the company on each risk that it has undertaken. This increase in predictability helps protect the company's solvency. The short of it is that on an actuarial basis with nearly a million people in the County risk distribution can be achieved and we should not have a year where we would have a spike with say 200,000 ambulance transports. I do not see any need to go outside the non-fee ambulance system that we have paid by our taxes, which, by the way, for the most part are deductible on our tax returns for those that itemized. Likewise some of the volunteer corporations have sufficient numbers of calls to achieve risk distribution, which corporations are funded in large part by contributions which are also deductible on our tax returns.

When one charges a fee some costs occur which should be considered by the County Council. Running the collection program can run say from 7 to 20% to collect a dollar (20% was the cost estimated in the proposal 5 years ago). Also training may be necessary that has nothing to do with the mission of the Fire and Rescue Service but is done by the collection agent staff solely to get claims through the claims people at the insurance companies on the medical necessity of the transport issue. Right now we seem to be free of any such window dressing kind of thing.

I should also point out that insurance is not just a little complicated. For example, most policies in the Federal Employees Health Benefit Program state some sort of coverage

for ambulance fees, however, they also have some general exclusions clauses which, in essence, take those stated the benefits away. For example, my plan does not cover: "[s]ervices or supplies for which no charge would be made if the covered individual had no health insurance coverage." Based on this general exclusion clause my plan has written me a letter dated June 11, 2008, stating that it would deny payment of the fee to the County. Maryland only mandates ambulance service coverage for certain small employer plans containing 50 or fewer persons and all of the other health plans that it regulates the parties are free to negotiate ambulance service coverage in or out. However, it is interesting to note that the small employer plan has a general exclusion provision barring payment for "[s]ervices for which a covered person is not legally or as a customary practice required to pay in the absence of a health benefit plan."

I see the Montgomery County proposal as being different from the Fairfax plan which the proponents have claimed to have copied. That is, in Fairfax, the county resident appears to be billed according to their waiver form and is asked not only to assert that they have no insurance but also to provided income information. In my submission to the Council I have it in writing that a Fairfax county resident without insurance with sufficient income will be required to pay their ambulance fee.

All of these ambulance fee proposals of the various counties that waive the co-pays and deductibles, in my personal view, create problems that can put paperwork burdens on residents that have flexible spending accounts tied into their health plans. For example, assume a doctor charges a patient $100 for his services and insurance pays $80 and the patient responsibility is $20. The connected health plan and Flex would result in $20 being transferred from the Flex account to the patient's personal bank account. This is what should happen because the patient owes the doctor the $20. If an ambulance fee is $400 and the insurer pays $300, the explanation of benefits will say the patient responsibility is $100. However, in the case of a waived $100 fee the $100 really has no business going out of the Flex account into the patient's personal bank account.

Some may perceive that the fee proposal operates unfairly and may this well generate confusion as to how the program actually works. I understand the current proposal not only co-pays are waived but deductibles are waived as well. Two different people could be transported at the some time but only the person whose explanation of benefits was processed before any other explanation of benefits first might get the benefit of the County's waiver program as to that deductible. In other words, I am assuming that the second party was unluckily enough to have his hospital bill processed first and when the County's medical transport bill was processed by the insurer the annual deductible had already be absorbed so there was no annual deductible available at that time for the County to waive (just the co-pays).

Sincerely,

William T. Sullivan

William T. Sullivan
301-340-9513

GEHA®

The Health Plan *for* Federal Employees

June 11, 2008

ES20080609373

WILLIAM T SULLIVAN
4 FALLS CHAPEL CT
POTOMAC MD 20854-2433

MEMBER NAME: WILLIAM T SULLIVAN
ID: 22893963
Patient: William T Sullivan
Re: Ambulance Charges

Dear Mr. Sullivan:

This is in response to the information you provided concerning the proposal of the Emergency Medical Services Transport Fee (EMST Fee) for ambulance services provided in Montgomery County, MD.

Thank you for bringing this information to our attention. We have discussed this matter with the insurance contract area of the Office of Personnel Management (OPM) and representatives of other FEHB Plans. If this proposal is enacted, GEHA would deny the EMST Fee from Montgomery County Fire and Rescue for Montgomery County residents. This is based on a specific exclusion on page 65 of the brochure that states we will not cover services or supplies for which no charge would be made if the covered individual had no health insurance coverage.

We have referred this issue to the Office of General Council of OPM.

Please continue to update us on the status of this proposal in Montgomery County.

If you have any questions, please contact me.

Sincerely,

Jane Overton
Vice President-Claims
Claims Department

JO:pl

Sullivan William T

From: Mangione, Katie [Katie.Mangione@fairfaxcounty.gov]
Sent: Tuesday, May 06, 2008 1:36 PM
To: Sullivan William T
Subject: RE: Montgomery County Ambulance Fee

I am not sure what you are saying. We have hardships based on income. You could not have $2M in income that you tell us about and get a waiver.

We look at the individual circumstances but would not automatically waive out of county residents.

From: Sullivan William T [mailto:William.T.Sullivan@IRSCOUNSEL.TREAS.GOV]
Sent: Tuesday, May 06, 2008 1:07 PM
To: Mangione, Katie
Subject: Montgomery County Ambulance Fee

<<Ambulance_fee.pdf>>

Hi Katie,

It appears that the Montgomery County fee plan is different for yours. For example, your waiver form asks for household income information. Would a Fairfax County resident without insurance but with $2 million of annual income and $50 million in net assets - get a free ride??

Any ideas? (It looks like your waiver form applies to Fairfax County residents and it is not just a form for out of county residents.)

The proposed legislation in Montgomery County 21-23A(c)(1) states that "[a] resident of Montgomery County is responsible for the payment of the emergency medical service transport fee only to the extent of the individual's available insurance coverage." As I understand it from Chief Graham information will be requested with one question only - do you have insurance? If not - the fee will not be collected. If one doesn't answer the inquiry from the county the first time on the "do you have insurance question" - 2 more inquiries will go out and no more inquiries will be made after that.

Thanks,

Bill Sullivan
(202) -622-7052

William.T.Sullivan@IRSCOUNSEL.TREAS.GOV

75

Montgomery County Volunteer Fire Rescue Association

P.O. Box 1374
Rockville, MD 20849
301-424-1297

Marcine D. Goodloe, President
Eric N. Bernard, Executive Director

Additional Comments of the MCVFRA on the Ambulance Fee Legislation to the Public Safety Committee Montgomery County Council

September 22, 2008

We appreciate the opportunity to submit additional information to the Council and Public Safety Committee on the proposed EMS Transport Fee. We continue to believe that the proposed legislation is fundamentally flawed on practical and philosophical grounds and should be rejected by the Council.

In the past several days, representatives of the County Executive have proposed modified legislation, pointing to Columbus, Ohio, as a model for how the billing process might work. It is troubling that County officials -- after proposing the ambulance fee months ago -- are now offering an entirely new model for how the basic billing procedures will work, allowing little time to investigate whether the Columbus system works as County officials are suggesting.

I. Will Residents Be Charged for EMS Service?

County officials originally pointed to Fairfax County as a model for the EMS transport fee. Previously, we provided documentation showing that all Fairfax residents receive a bill for EMS transports -- residents with insurance may still receive a bill for deductibles and/or co-pays, while uninsured residents receive a bill for the entire EMS transport fee. To obtain a waiver of the fee, Fairfax residents must submit extensive financial, tax, or other documentation to demonstrate financial hardship; presumably residents who are not indigent or meet strict poverty levels must pay the fee. This documentation is available at www.**fairfaxcounty**.gov/fr/ems_billing/FRD-006.pdf.

County officials now point to Columbus, Ohio, as a model for billing that avoids sending residents any bill. However, the County's own financial projections show annual revenue of approximately $1 million per year from "self pay."

	Year 1	Year 4
Self-Pay Transports	15,954	17,945
Self-Pay Charges	$ 7,920,960	$10,219,540
Self-Pay Revenues	$792,096 (10% of self-pay charges)	$1,021,954 (10% of self-pay charges)

**See Appendices to Page, Wolfberg & Wirth ("PWW Report") (which was included in the package of materials for the Council hearing in July 2008).*

Assuming an average transport fee of $500, this means (using Year 4 estimates) that nearly 20,000 individuals (i.e., $10 million divided by $500 per transport) will receive a bill for payment and approximately 2,000 individuals will, in fact, pay a fee for emergency ambulance service.

This amount of revenue cannot be attributed to transports of out-of-county residents, since the self-pay transport figure cited above translates into 50 transports/day. We have seen no evidence that 50 non-county residents are transported each and every day by MC EMS units.

II. County Revenue Estimates

We continue to believe that County officials are vastly overstating the amount of revenue that will be generated by the ambulance fee, particularly in the first several years of operation.

A. Impact of "Soft" Billing

As demonstrated above, the County's revenue estimates assume thousands of people will receive and pay the EMS transport fee. If these individuals are not, in fact billed, the revenue estimates should be lowered accordingly. Also, we have seen no evidence that the County has examined how the Columbus, Ohio, approach -- which appears to be different than the process in jurisdictions near Montgomery County -- will impact the revenue estimates that were developed based on the old County proposal.

B. Documentation Requirements

The report by the County's outside consultant/law firm states that the revenue projections "[a]ssume complete documentation necessary to support billing decisions; crew documentation training recommended." (See PWW Report, "Notes and Assumptions" for each year's revenue projections). The report also states:

"Detailed documentation training will be required of all EMS personnel in the County to fully realize these revenue projections. Montgomery County policymakers and budget officials might want to take this factor into account when considering their anticipated EMS revenue budgets and reduce the projections by some estimated favor (for instance, 40% in Year One, 30% in Year Two, 20% in Year Three, and 10% in Year Four) to account for this unpredictable variable." (PWW Report, page 7 under "Patient Care Documentation").

Despite these explicit caveats, the April 14, 2008 Memorandum from Joseph Beach (OMB Director) to Michael Knapp states that "the legislation is expected to result in revenues of $7.05 million in FY09, assuming mid-year implementation, and annual revenues of $14.8 million in FY10 ...."

The truth is that while County budget officials promise $14.8 million in 1st year revenue, under the County's own estimate the actual amount is likely to be closer to $8 million/year -- and even that amount overstates the likely near-term revenues.

III. Administrative Costs of the Ambulance Fee

The costs of administering the ambulance fee are substantial. According to numbers recently circulated by Joe Beach, Office of Management and Budget, the administrative costs would approach $2 million/year (5.5% of total revenue). These administrative costs are more than the County is proposing to share with all of the local fire/rescue departments combined. This is a horribly inefficient way to bolster fire/rescue revenues.

Perhaps more importantly, we believe the County is understating the administrative costs. The 2008 Annual Budget of the City of Columbus, Ohio -- which is the new model cited by MC officials -- projects that administrative fees consumer 20% of overall revenue.

- The EMS third-party reimbursement program that began in January 2003 is expected to generate $9 million in 2008. The 2008 EMS billing contract is budgeted at $1.8 million.

http://finance.columbus.gov/AboutUs/Financial_Management/Budget_Office/index.asp

County officials should be questioned on how to square these figures. If Columbus is the model, why isn't the County using numbers from Columbus for the administrative costs?

IV. Will Residents Be Reluctant to Call 911?

We recognize the difficulty in proving whether an ambulance fee will, in fact, deter anyone from calling 911. At the July 2008 Council meeting, the Council questioned whether Fairfax officials have collected and/or analyzed refusals. We believe these questions remain unanswered.

We do, however, have concerns about Fairfax's experience. While it is true that annual EMS transports continued to increase after Fairfax imposed a fee, EMS transports -- when corrected for population growth -- (1) decreased after the EMS fee was imposed and (2) have remained below the pre-fee levels. While we do not know if the fee contributed in any way to the drop in EMS calls, we believe the Council should ask the County officials to further examine the impact in Fairfax County rather than relying on the sweeping -- and largely unsupported -- assertions that the fee has not deterred anyone from calling 911.

V. Impact on Community-Based Fire/Rescue Departments

Shifting from the impact on patients to the impact on the fire/rescue system, we believe an ambulance fee is fundamentally at odds with the notion of a volunteer community service. We simply don't understand how the County can charge hundreds of dollars for a service that often times is provided for free by volunteers and/or using apparatus and equipment provided by community fire/rescue departments. Imposing such a fee would undermine volunteer morale and undermine the close bond and accountability that is a hallmark of community-based fire/rescue departments.

The County's proposal also does not address the substantial burden that will be imposed on volunteer and career personnel in completing the paperwork necessary to facilitate billing. The County's own outside consulting/law firm has stated that accurate and complete documentation is essential to billing, and completing this paperwork will be a burden on fire/rescue personnel. Rather than expeditiously restocking and returning units to service at hospitals, EMS crews will need to spend time on paperwork. And rather than adding new classes to improve pre-hospital care, fire/rescue personnel will need to take courses in healthcare billing requirements. This is additional training hours to our volunteers which are already exceeding other local jurisdictions training levels and hours by 100% and greater in some cases!

VI. Mutual Aid Issues

We agree that it is unfair for other jurisdictions to charge Montgomery County residents for incidents occurring in those jurisdictions, when Montgomery County does not impose reciprocal fees. However, we believe it would be relatively easy (and lawful) to negotiate an agreement with these jurisdictions to exempt Montgomery County residents from such fees. We have reviewed the transport fee legislation for PG County, Washington DC, and Frederick County, and believe an agreement would not require legislative action. The Council should direct the County executive to explore such options to correct this situation.

* * * * *

Based on the foregoing, we believe there are simply too many identified flaws and too many unanswered questions for the Council to move forward on any ambulance fee legislation offered by the County Executive. This is particularly true given that County officials are now pointing to an entirely new model -- Columbus, Ohio -- a jurisdiction that bears few similarities to Montgomery County.

We would be happy to answer questions or provide more information upon request.

Review and Analysis of Fairfax County EMS Responses 2002 to 2007

Ambulance fee supporters claim that imposing a charge of $300-$800/transport will not deter people from calling 911, often citing to the experiences of other jurisdictions. For example, the EMS Transport Fee section of the County's website currently says:

> "There is no evidence that those in need of transport will be dissuaded from calling 911 because their insurance is going to be billed or because they are uninsured. In the jurisdictions that have been collecting this fee, there is no evidence of that happening." (1)

Fairfax County began billing for ambulance service in 2005. While total EMS calls in Fairfax County have increased steadily in the past several years, the number of calls when corrected for population increases actually decreased from 2004 to 2005. Since that time, EMS calls (when corrected for population growth) have remained below the 2004 level.

While the reasons for call volume changes are not clear, the statistics raise the question: Why did EMS call volume drop from 2004 to 2005? And why has EMS call volume remained below the 2004 level?

Before any ambulance fee is imposed, credible studies or analyses should be performed (e.g., through surveys of impacted populations) to determine whether, in fact, ambulance fees have deterred some Fairfax County residents from calling 911.

Fiscal Year	Population	Call Volume	EMS Calls	EMS Calls % of Pop	Change in EMS Calls % of Pop
2002	964712	89,246	60,685	6.29%	
2003	984366	87,621	60,306	6.13%	- 0.16
2004	1007800	91,373	62,420	6.19%	+ 0.06
2005	1041200	88,591	61,636	5.92%	- 0.27
2006	1049333	90,086	62,036	5.91%	- 0.01
2007	1077000	92,087	64,088	5.95%	+ 0.04

Sources:

(1) http://www.montgomerycountymd.gov/mcgtmpl.asp?url=/content/pio/ems/facts.asp
(2) http://www.fairfaxcounty.gov/fr/stats/

Suburban Hospital

www.suburbanhospital.org

Fire Chief Thomas W. Carr, Jr.
Montgomery County Fire and Rescue Service Hqts.
101 Monroe Street, 12th Floor
Rockville, MD 20850

September 18, 2008

037996

Dear Chief Carr,

Suburban Hospital appreciates the partnership we have with Montgomery County Fire and Rescue Service, and the way our two organizations have served together to provide health services to our county residents. We understand, in a time of increasing demand and tight budgets, your need to seek third party payment for ambulance transports to hospitals for those Montgomery County patients who have applicable health insurance. We further understand you are seeking assistance from hospitals to ensure that the billing process is effective and separate from the provision of the very high quality services which your team delivers every day for everyone irrespective of payment.

Toward that end, Suburban Hospital agrees to provide Montgomery County Fire and Rescue Service with access to patient demographic and insurance data needed to bill for ambulance transport payment. We have a mechanism in place to make such data for select groups of patients available to other health providers that is HIPAA compliant. In each case, the date provided would be the demographic and insurance data for patients arriving at Suburban Hospital by ambulance transport fees.

Subsequent updates to accounts already reported would also be included in our transfer file so that insurance data located after the visit could be obtained as well as the information given at registration.

Because Suburban Hospital shares Montgomery County Fire and Rescue Service's interest in administrative efficiency and already has this system in place, we will not charge you for access to the patient demographic and insurance data if you can work with the data file that includes all ambulance transports. If your proposal becomes County law, Suburban Hospital's information services division will coordinate the mechanics of the data transfer with your administrative staff and billing company.

Again, Suburban Hospital appreciates the funding needs of Montgomery County Fire and Rescue Service and would be pleased to provide you with the data as outlined above.

Sincerely,

Brian A. Gragnolati
President and CEO

Cc: Michael Knapp, President, Montgomery County Council
Isiah Leggett, Montgomery County Executive